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No. 99-

IN THE
# Supreme Court of the United States

VALERIE WASHINGTON,

*Petitioner,*

*v.*

HEALTH COST CONTROLS OF ILLINOIS, INC.,

*Respondent.*

**ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT**

## PETITION FOR A WRIT OF CERTIORARI

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## QUESTIONS PRESENTED

Whether an assignee of a reimbursement claim qualifies as a fiduciary so as to create federal jurisdiction under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.*

Whether a contractual claim for reimbursement of medical expenses is an action for "equitable relief" within the meaning of ERISA's jurisdiction provision, or an action for money damages outside ERISA jurisdiction.

Whether a party to an unsuccessful removal from state to federal court may file a mirror-image lawsuit in federal court after the original case has been remanded to state court for want of federal jurisdiction.

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Valerie Washington respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit in this case.

## OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-15a) is reported at 187 F.3d 703. The opinion of the district court (App., *infra*, 16a-43a) is unreported.

The opinion of the district court remanding the prior filed mirror image case to state court (App., *infra*, 56a-69a) is reported at 883 F. Supp. 264. The order of the court of appeals denying a writ of mandamus in that case (App., *infra*, 53a-55a) is not reported. The order of the Illinois Appellate Court holding that the mirror image case was not preempted by federal law (App., *infra*, 42a-52a) is not reported.

## JURISDICTION

The judgment of the court of appeals was entered on August 10, 1999. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

## STATUTORY PROVISIONS INVOLVED

The relevant statutes can be found in Appendix F to this petition at pages 70a-72a.

## STATEMENT OF THE CASE

This case involves the jurisdiction of federal courts under the Employee Retirement Income Security Act of 1974 ("ERISA"), 88 Stat. 832, as amended, 29 U.S.C. § 1001

*et seq.*, and the binding force of a prior remand order on a subsequent related filing.

1. Valerie Washington was injured in an auto accident with an uninsured motorist. Her employer furnished medical benefits through Michael Reese Health Plan, Inc., which later merged with Humana Health Plan, Inc. An arbitration panel awarded Washington $60,000 pursuant to her uninsured motorist coverage, and Health Cost Controls of Illinois asserted a right to reimbursement in the amount of $10,580.15 for medical expenses. Washington disputed Health Cost's claim for reimbursement.

The parties agreed to deposit the disputed amount in an interest bearing escrow account pending adjudication of their rights. Washington brought suit in Illinois state court against Health Cost and others seeking a declaration of her right to the money. Health Cost removed the case to federal district court, basing federal jurisdiction on ERISA. On April 20, 1995, the federal district court remanded Washington's suit to state court, holding that the case did not arise under ERISA, there was no substantial question of federal law involved, and no federal question jurisdiction. *Washington v. Humana Health Plan, Inc.*, 883 F. Supp. 264 (N.D. Ill. 1995).

2. Two months later, Health Cost brought the present suit in federal court, seeking a declaration that it was entitled to the money in the escrow account based on the reimbursement provisions of the Michael Reese and Humana health plans. The district court denied Washington's motion to dismiss for lack of subject matter jurisdiction, and granted Health Cost's motion for summary judgment, concluding that (1) Health Cost's "status as an assignee for collection"

satisfied the ERISA fiduciary requirement, (2) Health Cost's request for restitution satisfied the ERISA "equitable relief" requirement, and (3) Health Cost's subsequent filing was not barred by the prior remand order.

Meanwhile, Washington's lawsuit proceeded in state court. The trial court judge denied Health Cost's motion to dismiss based on ERISA preemption, and certified the preemption issue for interlocutory appeal. The Illinois Appellate Court concluded that Health Cost's claim for reimbursement had "too tenuous or remote an effect on employee benefit plans to warrant" preemption under ERISA. On remand, the state trial court dismissed Washington's lawsuit based on the pendency of the federal proceedings, and Washington took an appeal from that dismissal. Washington's appeal is pending in the Illinois Appellate Court.

3. The court of appeals affirmed the judgment in favor of Health Cost against Washington, but the court of appeals disagreed with nearly all of the reasoning of the district court. First, the court of appeals observed, contrary to the district court's reasoning, that a ruling by a court that it lacks jurisdiction is generally *res judicata* on the issue of that court's jurisdiction. The court of appeals concluded, however, that a remand order based on 28 U.S.C. § 1447(c) is not *res judicata*, because such a remand order is unappealable under 28 U.S.C. § 1447(d).

Next, the court of appeals laid down a general rule that assignees are fiduciaries within the meaning of ERISA's jurisdiction provision, stating "By virtue of the assignment, the claims became Health Cost's property and Health Cost determines in its sole discretion which ones are meritorious

and what to do to collect them." Finally, the court of appeals held that, while restitution was not an "equitable remedy" in this case, Health Cost's claim for reimbursement could be described as a request for the imposition of a constructive trust. The Seventh Circuit recognized that this holding was contrary to the Ninth Circuit's decision in *FMC Medical Plan v. Owens*, 122 F.3d 1258 (9th Cir. 1997).

## REASONS FOR GRANTING THE PETITION

The Seventh Circuit held in this case that the assignee of a claim for money may invoke federal jurisdiction under the Employee Retirement Income Security Act of 1974 ("ERISA"), 88 Stat. 832, as amended, 29 U.S.C. § 1001 *et seq.* The Seventh Circuit's decision squarely conflicts with decisions of the Ninth and Eleventh Circuits, which have held that such claims fall outside the jurisdiction conferred by Congress. In holding that the assignee of a claim for money may sue in federal court, the Seventh Circuit has greatly expanded ERISA jurisdiction, effectively nullifying the requirement that suit be brought by an ERISA fiduciary for equitable relief. 29 U.S.C. § 1132(a)(3).

The Seventh Circuit further held that a decision remanding a case for want of federal jurisdiction was not binding in a subsequent suit between the same parties involving the same claim. Congress prohibited review of remand orders, even erroneous ones, in order to prevent protracted litigation of jurisdictional issues. *See Thermtron Products, Inc. v. Hermansdorfer*, 423 U.S. 336, 351 (1976). By interpreting nonreviewability to deprive remand orders of their *res judicata* effect, the Seventh Circuit opened up all remand orders to collateral attack, and rendered 28 U.S.C. § 1447(d) a dead letter.

This Court's review is necessary to clarify the limitations imposed by Congress upon federal jurisdiction, and to vindicate legislative and judicial policies concerning the finality of jurisdictional decisions.

1. Section 502(e) of ERISA provides for federal jurisdiction of civil actions "brought by the Secretary, or by a participant, beneficiary [or] fiduciary" of an ERISA plan. 29 U.S.C. § 1132(e)(1). Section 502(a)(3) of the Act provides that a civil action may be brought by a participant, beneficiary, or fiduciary

> (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or
>
> (B) to obtain other appropriate equitable relief
>
> (i) to redress such violations or
>
> (ii) to enforce any provisions of this subchapter or the terms of the plan.

29 U.S.C. § 1132(a)(3). In this case, Health Cost invokes federal jurisdiction as a fiduciary or not at all.

Section 3(21)(A) of ERISA defines a "fiduciary" as one who exercises discretionary authority or control respecting the management or administration of a plan, or respecting the management or disposition of plan assets. 29 U.S.C. § 1002(21)(A). The Seventh Circuit concluded that Health Cost was a fiduciary pursuant to an assignment of reimbursement claims:

> By virtue of the assignment, the claims became Health Cost's property and Health Cost determines in its sole discretion which ones are meritorious and what to do to collect them.

App., *infra*, 8a-9a. While the transfer of the reimbursement claim accounts for Health Cost's discretion, the act of receiving an assignment hardly qualifies as an exercise of discretion in the management or administration of the plan, and Health Cost's disposition is not of plan assets, but its own.

The Seventh Circuit's decision in this case is at odds with the decision of the Eleventh Circuit in *Chapman v. Klemick*, 3 F.3d 1508 (11th Cir. 1993), and with the decision of the Ninth Circuit in *Nieto v. Ecker*, 845 F.2d 868 (9th Cir. 1988). In *Chapman*, the Eleventh Circuit rejected the argument that a contractual claim for reimbursement converted settlement proceeds into an asset of the plan. 3 F.3d 1508, 1510. And in *Nieto v. Ecker*, the Ninth Circuit rejected the argument that an attorney charged with collecting contributions was a fiduciary, commenting

> This argument proves far too much. Under this rationale, anyone performing services for an ERISA plan — be it an attorney, an accountant, a security guard or a janitor — would be rendered a fiduciary insofar as he exercised some control over trust assets. . . .

845 F.2d 868, 870-71.

If Congress had intended to confer federal jurisdiction upon suits by anyone having a connection with an ERISA

plan, then it surely could have done so more simply than it did in the "six carefully integrated civil enforcement provisions found in § 502 (a) of the statute." *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 146 (1985). This Court should review the Seventh Circuit's decision to resolve the tension in the case law over the breadth of fiduciary standing, and to restore the limits placed by Congress on ERISA jurisdiction.

2. Congress also limited federal jurisdiction of cases brought by ERISA fiduciaries to actions for "appropriate equitable relief." 29 U.S.C. § 1132(a)(3). In *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), this Court interpreted this language to refer to those categories of relief that were typically available in equity as distinguished from classic forms of legal relief. A claim for reimbursement pursuant to a contract is a claim for legal relief, not equitable relief. *FMC Medical Plan v. Owens*, 122 F.3d 1258 (9th Cir. 1997).

In deciding not to follow the Ninth Circuit here, the Seventh Circuit recognized that many remedies were neither inherently legal nor inherently equitable, but depended upon the cause of action for their legal or equitable nature. App., *infra*, 9a-10a. *See also Gulf Life Insurance Co. v. Arnold*, 809 F.2d 1520 (11th Cir. 1987) (declaratory judgment action may be legal or equitable depending on nature of issues). The Seventh Circuit acknowledged that money damages are a classic form of legal remedy, but the court reasoned that Health Cost was not seeking damages, "or indeed any form of payment," from Washington. App. *infra*, 10a. Surely, the court of appeals elevated form over substance in concluding that Health Cost's action seeking payment of $10,580.15 was not an action for payment

at all, but a request for the imposition of a constructive trust over Washington's "claim" to the money.

This Court should review the decision of the Seventh Circuit to resolve the conflict between this case and *FMC Medical Plan v. Owens*, 122 F.3d 1258 (9th Cir, 1997), and to guide the lower courts in deciding ERISA jurisdiction based on the substance of the action rather than the characterizations of the parties.

3. Perhaps the most puzzling aspect of the court of appeals' decision in this case is the nullification of the remand order in *Washington v. Humana Health Plan, Inc.*, 883 F. Supp. 264 (N.D. Ill. 1995). The Seventh Circuit recognized that the ruling of a court that it lacks jurisdiction is normally *res judicata* on the issue of jurisdiction, and the court recognized that Health Cost's action was a "mirror-image" of the *Washington v. Humana* case, involving the same cause of action. App., *infra*, 6a-7a. The Seventh Circuit concluded, however, that remand orders are not binding because they are not appealable. *Id.*, 7a.

This cannot be the law. As this Court has said:

> The peace and order of society demand that matters distinctly put in issue and determined by a court of competent jurisdiction as to parties and subject matter, shall not be retried between the same parties in any subsequent suit in any court.

*Johnson Steel Street Rail Co. v. Wharton*, 152 U.S. 252, 257 (1894). The district court in *Washington v. Humana* had jurisdiction to decide its jurisdiction, and the remand order was "immunized from all forms of appellate review"

precisely to avoid the protracted litigation of jurisdictional issues conducted in this case. *Thermtron Products, Inc. v. Hermansdorfer*, 423 U.S. 336, 351 (1976).

Congress could not have intended the nonreviewability of remand orders to nullify their binding force in subsequent mirror-image actions. The decision of the Seventh Circuit in this case subjects every remand order to collateral attack, eviscerating the legislative policy of nonreviewability as well as the judicial policy of finality. This Court should review the Seventh Circuit's decision to correct the far-reaching consequences of this erroneous ruling.

## CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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# APPENDIX

**APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT DATED AND DECIDED AUGUST 10, 1999**

In the

# United States Court of Appeals

## For the Seventh Circuit

No. 98-3241

HEALTH COST CONTROLS OF ILLINOIS, INC.,

*Plaintiff-Appellee,*

*v.*

VALERIE WASHINGTON,

*Defendant-Appellant.*

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 95 C 3806—**David H. Coar, *Judge*.**

ARGUED APRIL 8, 1999—DECIDED AUGUST 10, 1999

Before POSNER, *Chief Judge*, and EASTERBROOK and MANION, *Circuit Judges*.

POSNER, *Chief Judge*. Health Cost Controls brought suit against Valerie Washington, a participant in an employee welfare plan sponsored by her employer but administered in relevant part first by Michael Reese Health Plan, Inc. and later, when Humana bought Michael Reese, by Humana Health Plan, Inc. The suit sought reimbursement of certain benefits that the plan had paid her. The plan assigned its claim to Health Cost, which is why Health Cost is the plaintiff, rather than the plan. The case has a tangled history that raises jurisdictional issues. Ten years ago Washington was injured in an auto accident with an

uninsured motorist. The plan paid her medical expenses. She obtained another $60,000—including $10,580.15 for medical expenses—from an automobile insurance policy that provided uninsured-motorist benefits. The insurance company's check for the medical expenses, rather than being made out just to her, was made out to her and Health Cost jointly, because of the latter's claim to be entitled to this money to reimburse it for having paid Washington's medical bills. Washington's lawyers deposited the check in an interest-bearing escrow account (where it remains to this day) pending a determination of which of the payees was entitled to it. Health Cost took the position that the terms of the plan entitled it to this money as subrogee. Washington disagreed and brought suit in an Illinois state court against Health Cost and the plan for a declaration that she was entitled to keep the money. Health Cost removed the suit to federal district court, basing federal jurisdiction on ERISA. See 29 U.S.C. § 1132(a); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66 (1987); *Speciale v. Seybold*, 147 F.3d 612, 615 (7th Cir. 1998). The district judge, disagreeing that it was an ERISA suit, remanded the case to the state court. *Washington v. Humana Health Plan, Inc.*, 883 F. Supp. 264 (N.D. Ill. 1995). Two months later, Health Cost brought the present suit, which seeks primarily a declaration that the money in the escrow account belongs to it, and obtained summary judgment, precipitating this appeal. The state court recently dismissed Washington's suit, without prejudice, because of the pendency of Health Cost's parallel federal case.

There is, to begin with, a question of our appellate jurisdiction. The judgment order entered by the district court merely states that the plaintiff's motion for summary judgment is granted and that "this case is closed." The grant of summary judgment is not, however, the entry of a judgment, despite the name, *Massey Ferguson Division v. Gurley of Varity Corp.*, 51 F.3d 102, 104 (7th Cir. 1995);

*Abbs v. Sullivan*, 963 F.2d 918, 923 (7th Cir. 1992); *Landry v. G.B.A.*, 762 F.2d 462 (5th Cir. 1985) (per curiam), and despite the misleading statement in the Wright and Miller treatise that "a summary judgment completely disposing of all claims among all parties is final, *just as any other such judgment*." 15B Charles Alan Wright, Arthur R. Miller & Edward H. Cooper, *Federal Practice and Procedure* § 3914.28, p. 203 (2d ed. 1992) (emphasis added). A judgment in favor of a plaintiff is a statement of the relief being ordered; if in favor of the defendant, it is ordinarily a statement that the plaintiff's suit is dismissed; in either case the judgment is the bottom line. *Grun v. Pneumo Abex Corp.*, 163 F.3d 411, 422 n. 8 (7th Cir. 1998); *Massey Ferguson Division v. Gurley of Varity Corp., supra*, 51 F.3d at 104; *United States v. Menendez*, 48 F.3d 1401, 1408-09 (5th Cir. 1995) (per curiam). Summary judgment is not relief. It is merely a procedural premise for relief. The relief is whatever the party moving for summary judgment was seeking and the court agrees the party is entitled to.

There are two specific ways in which the grant of a motion for summary judgment will often fail to satisfy the criteria for an appealable order. The first is lack of finality, and the second lack of definiteness. *United States v. Allen*, 155 F.3d 35, 39 (2d Cir. 1998); 15B Wright, Miller & Cooper, *supra*, § 3914.28, pp. 204-06. Summary judgment, we repeat, is not a judgment; but if the judge indicates, as he seems to have done here when he said "this case is closed," that the grant of summary judgment is the last order he plans to enter—that he has finished with the case—then the grant becomes the final order in the case and objections based on lack of finality fall away. E.g., *Massey Ferguson Division v. Gurley of Varity Corp., supra*, 51 F.3d at 105; *Abbs v. Sullivan, supra*, 963 F.2d at 923. Such a summary judgment order may also be sufficiently definite to be appealable. The clearest case would be where the judge granted summary judgment to the

defendant and accompanied the grant with a statement that the case was closed. It would be clear both that the order was final and that it amounted to a dismissal of the suit. E.g., *Minnesota v. Kalman W. Abrams Metals, Inc.*, 155 F.3d 1019, 1023 (8th Cir. 1998). The absence of a formal judgment order (see Fed. R. Civ. Pro. 58) would not affect our jurisdiction. E.g., *Shalala v. Schaefer*, 509 U.S. 292, 303 (1993); *Richmond v. Chater*, 94 F.3d 263, 266 (7th Cir. 1996); *Massey Ferguson Division v. Gurley of Varity Corp., supra*, 51 F.3d at 105.

When, however, the grant of summary judgment is in favor of a plaintiff who is seeking a money judgment, then failure to enter an order directing the defendant to pay a specified sum may indeed be an event of jurisdictional significance. For it may leave unclear just what the judge has decided. It did here. The judge may have thought the amount of Health Cost's entitlement too obvious to warrant writing down the number of dollars that Valerie Washington must pay. He was wrong. What a plaintiff asks for in his complaint and what he is entitled to by way of judgment need not be the same number even if he wins the case, if only because a plaintiff often is entitled to prejudgment interest, *Uphoff v. Elegant Bath, Ltd.*, 176 F.3d 399, 410 (7th Cir. 1999); *Gorenstein Enterprises, Inc. v. Quality Care-USA, Inc.*, 874 F.2d 431, 436 (7th Cir. 1989); *Motion Picture Ass'n of America, Inc. v. Oman*, 969 F.2d 1154, 1157 (D.C. Cir. 1992), the amount of which cannot be determined until the judgment is entered. If a request for prejudgment interest is made in the district court we do not have appellate jurisdiction over a judgment in favor of the plaintiff until the district court acts on the request, *Osterneck v. Ernst & Whinney*, 489 U.S. 169 (1989), unless, possibly, only a mechanical calculation is required, that is, there is no issue concerning entitlement or amount. E.g., *Production & Maintenance Employees' Local 504 v. Roadmaster Corp.*, 954 F.2d 1397, 1401-02 (7th Cir. 1992); *Pratt v. Petroleum*

*Production Management, Inc. Employee Savings Plan & Trust*, 920 F.2d 651, 656 (10th Cir. 1990).

Maybe the judge was confused by the fact that Health Cost asked for a declaratory judgment rather than an order to pay. Rather than trying to collect money directly from Washington, who for all we know doesn't have any and who in any event might not be suable for damages under ERISA (a question we need not decide, however), Health Cost wants to get its paws on the money in the escrow account, which Washington does not control. It wants a declaration that it can take to the escrow agent as proof that the agent should turn over the money to it. But all this means is that instead of ordering the defendant to pay a specified sum of money to the plaintiff, the judge should have declared the plaintiff's right to a specified sum of money, or, alternatively and equivalently, to the balance in the escrow account. A declaratory judgment declares the rights of the parties; it does not "declare" merely that one of the parties has obtained summary judgment.

The requirement that the judgment make clear what the plaintiff is or is not entitled to is not a niggling, petty technicality; it is not a technicality at all. When there is uncertainty as to what the plaintiff is entitled to, the seeds of piecemeal appealing are sown; an appeal from an order entered during the postjudgment collection phase of a lawsuit is likely if the amount to be collected remains in dispute after the judgment has been affirmed. As bad as multiple appeals in the same case is uncertainty when and whether an appeal is possible. When a defective judgment is entered, the parties' lawyers have a duty, not here fulfilled, as officers of the court to advise the judge of the need to enter a proper, amended judgment. Cf. *Richmond v. Chater*, *supra*, 94 F.3d at 267.

But when it is clear both that the district court has resolved the parties' legal dispute and what the terms of

that resolution are, that resolution is appealable as a final decision within the meaning of 28 U.S.C. § 1291 even if there is no simple, concise statement of just what the judgment is. E.g., *Metzl v. Leininger*, 57 F.3d 618, 619-20 (7th Cir. 1995); *Abbs v. Sullivan*, *supra*, 963 F.2d at 923; *Vona v. County of Niagara*, 119 F.3d 201, 206 (2d Cir. 1997). That's the case here. It may have been unclear when the district court entered "judgment" just how much interest Health Cost would be entitled to (if we affirmed) on the $10,580.15 that had been sitting in the escrow account since the spring of 1994; but at the argument of the appeal, the parties agreed—consistent with Health Cost's having cast its request for relief in terms of a declaration of its entitlement to the escrowed money—that if we affirm, Health Cost is entitled to whatever money is sitting in the account, neither more nor less. The parties having thus removed the ambiguity in the district court's judgment, that judgment is appealable. *J.D. Pharmaceutical Distributors, Inc. v. Save-On Drugs & Cosmetics Corp.*, 893 F.2d 1201, 1208 (11th Cir. 1990); *O'Boyle v. Jiffy Lube Int'l, Inc.*, 866 F.2d 88, 92 (3d Cir. 1989); 15B Wright, Miller & Cooper, *supra*, § 2914.28, pp. 203-04.

There is also a question—actually there are several questions—about the district court's jurisdiction. The first and least is whether the earlier remand of Washington's mirror-image suit to state court on the ground that it was not within federal jurisdiction is res judicata in this suit. Health Cost argues not, on the erroneous ground that a dismissal (which the remand order had the effect of) for want of jurisdiction cannot have any res judicata effect because a ruling by a court that lacks jurisdiction over the case is a nullity. That is an oversimplification. A ruling by a court that it lacks jurisdiction is res judicata on the issue of that court's jurisdiction (provided—an essential qualification, as we're about to see—that res judicata is otherwise proper). A court is competent to decide its own jurisdiction even though it is not competent to decide the

merits of a case over which it lacks jurisdiction. *Okoro v. Bohman*, 164 F.3d 1059, 1062-63 (7th Cir. 1999).

An *unappealable* ruling, however, is not res judicata, *Warner/Elektra/Atlantic Corp. v. County of DuPage*, 991 F.2d 1280, 1282 (7th Cir. 1993); *Greenleaf v. Garlock, Inc.*, 174 F.3d 352, 359-60 (3d Cir. 1999); *Winters v. Diamond Shamrock Chemical Co.*, 149 F.3d 387, 394-96 (5th Cir. 1998); *Restatement (Second) of Judgments* § 28(1) (1980), and the district court's remand order was unappealable because the ground was lack of subject-matter jurisdiction. See 28 U.S.C. §§ 1447(c), (d); *Quackenbush v. Allstate Ins. Co.*, 517 U.S. 706, 711-12 (1996); *Thermtron Products, Inc. v. Hermansdorfer*, 423 U.S. 336, 345-46 (1976); *In re Florida Wire & Cable Co.*, 102 F.3d 866 (7th Cir. 1996). So the order doesn't conclude the issue whether the district court has jurisdiction over Health Cost's new and materially identical suit. *Nutter v. Monongahela Power Co.*, 4 F.3d 319, 322 (4th Cir. 1993); *Southern Leasing Corp. v. Tufts*, 804 P.2d 1321 (Ariz. App. 1991); cf. *Winters v. Diamond Shamrock Chemical Co., supra*, 149 F.3d at 395-96; but cf. *S.W.S. Erectors, Inc. v. Infax, Inc.*, 72 F.3d 489, 492 (5th Cir. 1996).

Washington next argues that Health Cost is not an ERISA fiduciary; and if not, Health Cost concedes, its suit is not an ERISA suit and there is no federal jurisdiction. An ERISA fiduciary is, so far as bears on this case, anyone who has substantial control over the assets, management, or administration of an ERISA plan. 29 U.S.C. § 1002(21)(A); *Lockheed Corp. v. Spink*, 517 U.S. 882, 890-91 (1996); *Varity Corp. v. Howe*, 516 U.S. 489, 502-03 (1996). Health Cost was hired by the plan administrator to administer the plan's claims for reimbursement from participants, such as Washington, who compares Health Cost to a lawyer hired by an ERISA plan to bring a suit on the plan's behalf. That lawyer would not be an ERISA fiduciary, *Associates in Adolescent Psychiatry, S.C. v. Home Life Ins. Co.*, 941 F.2d 561, 570 (7th Cir. 1991); *Hotel Employees & Restaurant Employees International Union Welfare Fund v.*

*Gentner*, 50 F.3d 719 (9th Cir. 1995); *Useden v. Acker*, 947 F.2d 1563, 1577-79 (11th Cir. 1991); *Nieto v. Ecker*, 845 F.2d 868, 870-71 (9th Cir. 1988); 29 C.F.R. § 2509.75-5, even though a lawyer is a fiduciary of his client. E.g., *In re Marriage of Pagano*, 607 N.E.2d 1242, 1247 (Ill. 1992); *Finley v. Marathon Oil Co.*, 75 F.3d 1225, 1230 (7th Cir. 1996). Just why a pension plan's lawyer should be excused from ERISA fiduciary status is a little obscure, but in *Associates in Adolescent Psychiatry* we suggested that it was because lawyers and other professionals who render services to the plan's administrator do not exercise "any decision-making authority over the plan or plan assets; the power to act for the plan is essential to status as a fiduciary under ERISA." 941 F.2d at 570. Lacking such power, there is less need in the interest of the plan to hedge the lawyer about with rules designed to assure that a fiduciary act with utmost loyalty and competence. Moreover, a professional who renders services to an ERISA plan is subject to whatever fiduciary or other duties his profession imposes upon him. An additional layer of fiduciary duty, the duty of an *ERISA* fiduciary, might add more to the expense of pension plans than to the safety of their assets—though along with the burden of being an ERISA fiduciary comes the advantage of access to the federal courts; that of course is where Health Cost wants to be.

Not being the plan's lawyer, Health Cost is not subject to the fiduciary duties that a lawyer has to his client. Yet it has considerably more discretion than the plan's lawyer, and this argues for making Health Cost a fiduciary on some other basis, namely ERISA. Assigned whatever legal claims the plan might have rather than merely retained to prosecute them as the plan's agent, Health Cost does not consult with the administrator on whether to take legal action, as in the ordinary lawyer-client setting. By virtue of the assignment, the claims become Health Cost's property and Health Cost determines in its sole discretion which ones are meritorious and what to

do to collect them. This is a broader power than that of a lawyer hired to handle a claim, or of an ordinary collection agent. Compare *Moores v. Greenberg*, 834 F.2d 1105, 1108 (1st Cir. 1987). Answering a question left open in a previous case brought by Health Cost, *Health Cost Controls of Illinois, Inc. v. Skinner*, 44 F.3d 535, 537 n. 3 (7th Cir. 1995), we hold that Health Cost is an ERISA fiduciary.

We are helped to this conclusion by a desire not to interfere with the widespread practice (see, e.g., 1 Jeffrey D. Mamorsky, *Employee Benefits Handbook* § 3.06, p. 3-28 (1998)), clearly contemplated by the statute itself (see 29 U.S.C. §§ 1002(16)(A), 1103(a)(2); 29 C.F.R. § 2509.75-8FR-12; Jay Conison, *Employee Benefit Plans in a Nutshell* 13, 206 (2d ed. 1998)) and so far as we know salutary, of splitting up the various functions involved in the administration of an ERISA plan among specialized providers of service. (That is illustrated here not only by the plan administrator's retention of Health Cost, but of the delegation by Washington's employer of the administration of a part of its employee welfare plan to another entity—Reese, succeeded by Humana.) To deny such specialists access to the federal courts under ERISA because they lack the full range of responsibilities of a traditional trustee would impede what appears to be an efficiency-promoting fractionating of fiduciary responsibilities that is consistent with an economy-wide trend toward specialization.

Washington also argues that the district court had no jurisdiction because the relief sought by Health Cost is not equitable, and ERISA authorizes only suits by fiduciaries that seek equitable relief. 29 U.S.C. § 1132(a)(3); *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993); *Reich v. Continental Casualty Co.*, 33 F.3d 754, 755 (7th Cir. 1994). One reply by Health Cost is that its suit is for restitution and that restitution is an equitable remedy. That is not true, although the point is sometimes overlooked, *Harris Trust & Savings Bank v. Provident Life & Accident Ins. Co.*,

57 F.3d 608, 615-16 (7th Cir. 1995); *Health Cost Controls of Illinois, Inc. v. Skinner, supra*, 44 F.3d at 537 n. 5; *Schwartz v. Gregori*, 45 F.3d 1017, 1022-23 (6th Cir. 1995), partly because of an unfortunate and surely unintended dictum in *Mertens*, that the plaintiffs were not seeking "a remedy traditionally viewed as 'equitable,' such as injunction *or restitution*." 508 U.S. at 255 (emphasis added). As we explained in *Continental Casualty*, restitution is a legal remedy when sought in a case at law and an equitable remedy when sought in a case in equity. *Reich v. Continental Casualty Co., supra*, 33 F.3d at 75. (There really isn't any question about this. See 1 Dan R. Dobbs, *Law of Remedies: Damages—Equity—Restitution*, § 1.2, p. 11; § 4.1(1), p. 556; § 4.1(3), pp. 564-65; §§ 4.2-.3 (2d ed. 1993).) But as we also explained, when sought as a remedy for breach of fiduciary duty restitution is properly regarded as an equitable remedy because the fiduciary concept is equitable. In this case, however, Health Cost, although a fiduciary, is not relying on a breach of fiduciary duty as the basis for its action. Washington, the defendant, is not a fiduciary and so is not accused of any breach of fiduciary duty.

She argues that this is a suit for damages and such a suit is of course legal, not equitable, as emphasized in *Mertens v. Hewitt Associates, supra*. But Health Cost is not seeking damages, or indeed any form of payment, from Washington. What it is seeking is best described as the imposition of a constructive trust on the money in the escrow account, see 1 Dobbs, *supra*, § 4.3(2), or, alternatively and equivalently, as we are about to see, on Washington's claim to the money; and Health Cost argues constructive trust as an alternative basis to restitution for its claim. A constructive trust is, of course, an equitable remedy. E.g., *Filipowicz v. American Stores Benefits Plans Comm.*, 56 F.3d 807, 812 (7th Cir. 1995); *Health Cost Controls of Illinois, Inc. v. Skinner, supra*, 44 F.3d at 538 n. 7;

*Anweiler v. American Electric Power Service Corp.*, 3 F.3d 986, 993 (7th Cir. 1993); *Bast v. Prudential Ins. Co.*, 150 F.3d 1003, 1010-11 (9th Cir. 1998). It is true that normally the defendant is sought to be made the (involuntary) trustee of money that is in his or her own custody, see, e.g., *Beatty v. Guggenheim Exploration Co.*, 122 N.E. 378, 380 (N.Y. 1919) (Cardozo, J.), while what Health Cost is seeking is a constructive trust in Washington's *claim* to the money in the escrow account. But if she is declared to be holding that claim in trust for Health Cost, then the latter can take the declaration to the escrow agent and get the money from him. The device of a constructive trust has often been used in just this way to transfer the beneficial interest from one joint account holder to another. *Hall v. Superior Federal Bank*, 794 S.W.2d 611, 617 (Ark. 1990); *Potts v. Emerick*, 445 A.2d 695 (Md. 1982); *First National Bank v. Curran*, 206 N.W.2d 317 (Iowa 1973); *Vesey v. Vesey*, 54 N.W.2d 385 (Minn. 1952).

So Health Cost is indeed seeking a constructive trust and while the Ninth Circuit appears to believe that the imposition of a constructive trust in an ERISA case is permissible only when there has been a breach of trust, *FMC Medical Plan v. Owens*, 122 F.3d 1258, 1261 (9th Cir. 1997), it has given no reason for this belief and there is no basis for it either in ERISA or in the principles of equity. Granted that in times of yore the constructive trust was available only as a remedy against trustees and other fiduciaries, 1 Dobbs, *supra*, § 4.3(2), p. 597, there is nothing to suggest that ERISA's drafters wanted to embed their work in a time warp. In ordinary trust law the historical limitation of the remedy has been abandoned. *Id.*, § 4.3(2), pp. 597-98; 5 Austin Wakeman Scott & William Franklin Fratcher, *Scott on Trusts* § 462 (4th ed. 1989). We do not think the motto of our law should be "let the dead bury the living." Alternative characterizations of Health Cost's claim (alternative to both resti-

tution and constructive trust)—as seeking to impose an equitable lien on the escrow account or seeking a mandatory injunction directing Washington to sign over her claim to the money—are also permissible, moreover, and they reinforce our conclusion that Health Cost's claim is securely equitable and so within the jurisdiction conferred on the district court by ERISA.

With all jurisdictional issues resolved we arrive at last at the merits. The question here is whether the plan documents entitle the plan to reimbursement for medical expenses that are paid to a participant in accordance with an insurance policy that provides coverage for an injury inflicted by an uninsured motorist. The plan itself is perfectly clear on this point. It says that the plan will cover the expense of "medical services for injury caused by a third party. . . . However, [the plan] has the right to be reimbursed for the value of services it has provided when a beneficiary receives payment from a third party," here the insurer. The summary plan description, however, says that the plan "will provide medical services and treatment for injuries caused by a third party. You must, however, assign to the [plan] all rights to obtaining reimbursement from *the third party* for medical services provided by or through the [plan]" (emphasis added). Read literally, this implies that the only reimbursement the plan can seek is from the injurer (the third party who causes the injury), who in this case was an uninsured motorist. When, however, the plan and the summary plan description conflict, the former governs, being more complete—the original, as it were, which the summary plan description excerpts and translates into language that may be imprecise because it is designed to be intelligible to lay persons—unless the plan participant or beneficiary has reasonably relied on the summary plan description to his detriment. *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1022-24 (7th Cir.

1998); *Senkier v. Hartford Life & Accident Ins. Co.*, 948 F.2d 1050, 1051 (7th Cir. 1991); *Chiles v. Ceridian Corp.*, 95 F.3d 1505, 1518-19 (10th Cir. 1996); *Aiken v. Policy Management Systems Corp.*, 13 F.3d 138, 140 (4th Cir. 1993).

We need not get into the issue of reliance here, or weigh the significance of the fact that the summary plan description states that "in case of a conflict or discrepancy between this booklet and the actual Plan provisions, the provisions of the Plan will govern your rights and benefits." For there is no conflict between the descriptions. Washington's interpretation of the passage that we quoted from the summary plan description makes no sense. The obvious purpose of the quoted language is to prevent double payment for the same claim. Had Washington been hit by an insured motorist, she would, she concedes, have been obligated to allow Health Cost to obtain reimbursement for the plan's medical expenses from the motorist, which is to say, as a practical matter, the motorist's insurer. We cannot fathom why it should make any difference if the motorist happens not to have any insurance, so that the victim's insurer picks up the slack. The quoted language is merely a clumsy paraphrase of the clear language of the plan itself. Senseless interpretations of ERISA summary plan descriptions as of other contractual documents should be rejected. E.g., *Grun v. Pneumo Abex Corp.*, *supra*, 163 F.3d at 420; *Delgrosso v. Spang & Co.*, 769 F.2d 928, 936 (3d Cir. 1985); see generally *Level 3 Communications, Inc. v. Federal Ins. Co.*, 168 F.3d 956, 958 (7th Cir. 1999).

One loose end remains to be tied up, however. Although we have spoken of "the plan itself" and quoted language from the summary plan description referring to "the Plan," Washington denies that the plan, on which Health Cost necessarily predicates its claim for reimbursement, was ever placed in evidence. What we (and Health Cost) have called "the plan" is a document entitled "Sub-

scriber's Service Agreement," which is in the record but which states that it (like the summary plan description) is only a "summary" and that the "Group Service Agreement," which is not in the record, is the real plan document.

This kind of confusion is all too common in ERISA land; often the terms of an ERISA plan must be inferred from a series of documents none clearly labeled as "the plan." See, e.g., *Milwaukee Area Joint Apprenticeship Training Comm. v. Howell*, 67 F.3d 1333, 1338 (7th Cir. 1995); *Horn v. Berdon, Inc. Defined Benefit Pension Plan*, 938 F.2d 125 (9th Cir. 1991) (per curiam). An uncontested affidavit in the record states that the Subscriber's Service Agreement, which is what Health Cost is treating as the plan, indeed provided the basis for administering the employee welfare plan. It is also uncontested that the "full benefits" that Washington received were determined in accordance with that document. Whether the Group Service Agreement even exists (it may have been issued by Michael Reese and lost in the shuffle when Humana acquired Reese), and whether if so it differs from the Subscriber's Service Agreement in any respect material to this case, we do not know. But having obtained benefits in accordance with the latter agreement, it ill behooves Washington to turn around and deny that the agreement is the authoritative plan document. It is not as if she were offering to reimburse Humana should it turn out that the Group Service Agreement entitles her to fewer benefits than the Subscriber's Service Agreement. Just as the employee welfare plan would be estopped to set up "the plan itself" as a defense to a claim for benefits if Washington had reasonably relied on the language of the summary plan description, so she is estopped to repudiate the plan document on the basis of which she obtained her full benefits, which she wishes to retain.

AFFIRMED.

*Appendix A*

A true Copy:

Teste:

_____

*Clerk of the United States Court of Appeals for the Seventh Circuit*

## APPENDIX B — MEMORANDUM OPINION AND ORDER OF THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION DATED AUGUST 7, 1998

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE NORTHERN DISTRICT OF ILLINOIS**
**EASTERN DIVISION**

No. 95 C 3806

JUDGE DAVID H. COAR

HEALTH COST CONTROLS OF ILLINOIS, INC.,
an Illinois Corporation,

Plaintiff,

v.

VALERIE WASHINGTON,

Defendant.

**MEMORANDUM OPINION AND ORDER**

The plaintiff in this case, Health Cost Controls of Illinois, Inc. ("HCC" or "Health Cost Controls") brought a two-count complaint against the defendant Valerie Washington alleging various theories under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et. seq.* Presently before the court are cross-motions for summary judgment filed by the plaintiff and the defendant. For the reasons set forth below, the plaintiff's motion is granted in part and denied in part, and the defendant's motion is denied.

*Appendix B*

## I. FACTS

The defendant was employed by the University of Chicago in 1989. (Plaintiff's Local Rule 12(M) Statement ("12(M) Pl.") ¶1; Defendant's Local Rule 12(N) Statement ("12(N) Def.") ¶1.) The plaintiff alleges that the defendant was a member of an employer paid health care plan, and states that the managed care service option of the plan was provided by Michael Reese Health Plan, Inc. ("MRHP"). (12(M) Pl. ¶1.) The defendant denies this allegation, citing plaintiff's failure to provide evidence to support this claim, In particular, the defendant focuses on the fact that the plaintiff has not submitted a copy of the plan document. (*Id.*) However, defendant does admit that health care services during some of this time were provided to her by MRHP. (12(N) Def. ¶2.)

On May 25, 1989, the defendant sustained injuries in an automobile accident, and thereafter received benefits from MRRP for treatment of her injuries. (12(M) Pl. ¶¶7-8; 12(N) Def. ¶¶7-8.) Plaintiff claims the amount of benefits defendant received was $10,580.15; defendant denies this portion of plaintiff's statement. (12(M) Pl. ¶8; 12(N) Def. ¶8.) The motorist responsible for defendant's injuries was not insured at the time of the accident. (12(N) Def. ¶20.) On January 30, 1990, plaintiff sent a letter to defendant's attorney, in which it stated its intention to seek reimbursement for the value of the services provided. (12(M) Pl. ¶9.) Defendant's attorney objected to the assertion of a right to reimbursement, but plaintiff received an incident report, filled out by defendant, dated December 9, 1991. (12(N) Def. ¶22; 12(M) Pl. ¶10.) Plaintiff also received a Reimbursement Agreement from

defendant; however, plaintiff only signed the portion of the agreement authorizing her auto insurance company to release records to the plaintiff. (12(M) Pl. ¶11; 12(N) Def. ¶11.)

On March 1, 1991, according to the plaintiff, Humana Health Plan, Inc. ("Humana") purchased substantially all of the of the operating assets of MRHP, including MRHP's interest in the reimbursement claim that is the subject of this dispute. (12(M) Pl. ¶3.) Defendant disputes this statement, citing plaintiff's failure to provide documents evidencing Humana's purchase. (12(N) Def. ¶3.) Subsequent to its purchase, Humana provided managed care services to the plan members (12(M) Pl. ¶4; 12(N) Def. ¶4), including the defendant.

The Subscriber's Service Agreement of the MRHP plan, in effect until March 1, 1991, contained the following reimbursement provision:

> Medical services for injury caused by a third party are provided to a beneficiary. However, MRHP has the right to be reimbursed for the value of the services it has provided when a beneficiary receives payment from a third party. The beneficiary is required to cooperate with MRHP in regard to such injuries and payments.

(12(M) Pl. ¶4.)

The Summary Plan Description of the MRHP plan contained the following reimbursement provision: "HMO Illinois will provide medical services and treatment for

injuries caused by a third party. You must, however, assign to HMO Illinois all rights to obtaining reimbursement from the third party for medical services provided by or through HMO Illinois."[1]

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1. The managed care service option of the Humana plan, effective beginning March 1, 1991, contained the following reimbursement provision:

> This provision applies when another party (person or organization) is or may be considered responsible for payment because of a member's injury or sickness for which benefits under the Group Plan have been provided.
>
> To the extent of such services provided, we are subrogated to all rights of recovery the member has against that other party and we may assert such rights independent of the member. Also, if the member has obtained or obtains a court judgment, settlement, or other monetary recovery from another party, because of the injury of sickness, we are subrogated to the proceeds of the third-party payment to the extent of benefits provided. If a third-party payment is made, we shall have first priority, over the member or any other party, to receive from the third party payment reimbursement of the benefits we have provided. This priority shall apply and reimbursement shall be required:
>
> 1. even though the third-party payment does not compensate the member for this or her whole loss;
>
> 2. whether or not liability for payment is admitted by the third party; or
>
> 3. whether or not such payment is itemized or called anything other than payment for medical expenses incurred.

(Cont'd)

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Plaintiff states that MRHP and Humana have assigned to plaintiff their rights to reimbursement related to the benefits defendant received in connection with her automobile accident, and further asserts that plaintiff has broad discretion over the enforcement of reimbursement rights and the monies collected from reimbursements. (12(M)

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(Cont'd)

> The member is obligated to cooperate with us to protect our subrogation rights and shall not prejudice our right to recovery and reimbursement, Failure to cooperate and prejudice of our rights shall occur if the member fails to:
>
> 1. complete a third-party information report, naming, among all other things:
>
>    a. the party who may be considered responsible for the injury or sickness; and
>
>    b. any current of anticipated third-party litigation, settlement negotiations, or other coverage;
>
> 2. give statements and proved information about the other parties or the injury or sickness when requested by us;
>
> 3. execute and deliver any other documents or do whatever else we reasonably require to secure our rights of subrogation;
>
> 4. obtain our consent prior to releasing the third party from liability for payment of medical expenses; or
>
> 5. reimburse us when a recovery is made from the third party.

(12(M) Pl. ¶6.)

Pl. ¶¶12-13.) Defendant denies these statements, citing plaintiff's failure to attach any assignment documents providing evidence to support its motion. (12(N) Def. ¶¶12-13.)

On May 11, 1994, defendant received $60,000 from her own auto insurance company, Allstate Insurance Company ("Allstate"), as a benefit of her uninsured motorist insurance policy. (12(M) Pl. ¶14.) Allstate issued two checks: one check was issued to Valerie Washington in the amount of $49,419.85 and a second check was issued to Valerie Washington, her attorneys, and HCC in the amount of $10,580.15. (12(M) Pl. ¶15.) The second check was placed in an interest-bearing escrow account pending the resolution of this dispute. (12(M) Pl. ¶16.) Defendant asserts that plaintiffs attorney agreed that the matter would be settled in state court, but plaintiff denies this assertion. (12(N) Def. ¶24; Pl.'s Response to Def.'s Local Rule 12(N) Statement ¶24.) The plaintiff has not been reimbursed for the medical care benefits provided to the defendant, (12(M) Pl. ¶17), the cost of which was $10,580.15.

On September 8, 1994, defendant filed a complaint for declaratory judgment and class action relief in the Circuit Court of Cook County, Illinois. (12(N) Def. ¶25.) On October 12, 1994, plaintiff filed its notice of removal from the Circuit Court of Cook County to the United States District Court for the Northern District of Illinois. (12(N) Def. ¶27.) On November 14, 1994, the defendant filed a motion for remand, which was granted on April 20, 1995 upon a determination that the case did not arise under ERISA, there was no substantial question of federal law involved, and no federal question jurisdiction, (12(N) Def. ¶28.)

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On January 9, 1996, the state court made a determination that ERISA was not applicable to the defendant's declaratory judgment action, which the plaintiff appealed. (12(N) Def. ¶30.) On December 4, 1996, the Illinois Supreme Court ordered the Illinois Appellate Court to consider the issue of ERISA preemption. (12(N) Def. ¶32.) This case is currently pending. (*Id.*)

Plaintiff alleges jurisdiction and venue over this dispute pursuant to ERISA and the federal common law, and the fact that the defendant resides in this district. (12(M) Pl. ¶¶18-19.) Defendant denies these allegations (12(N) Def. ¶¶18-19); however, as discussed *infra* in Section 111, these issues were resolved in earlier motions to dismiss by defendant.

## II. LEGAL STANDARD FOR MOTION FOR SUMMARY JUDGMENT

Summary judgment is proper "if the pleadings, depositions, answers to interrogatories and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed.R.Civ.P. 56(c); *Cox v. Acme Health Serv., Inc.*, 55 F.3d 1304,1308 (7th Cir. 1995). A genuine issue of material fact exists for trial when, in viewing the record and all reasonable inferences drawn from it in a light most favorable to the non-moving party, a reasonable jury could return a verdict, for the non-movant. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248, 106 S. Ct. 2505, 2510 (1986); *Hedberg v. Indiana Bell Tel. Co.*, 47 F.3d 928, 931 (7th Cir. 1995). The movant has

the burden of establishing that there is no genuine issue of material fact. *Celotex v. Catrett*, 477 U.S. 317, 323, 106 S. Ct. 2548, 2553 (1986). If the movant satisfies this burden, the non-movant must set forth specific facts that demonstrate the existence of a genuine issue for trial. Fed.R.Civ.P. 56(e); *Celotex*, 477 U.S. at 324, 106 S.Ct. at 2553.

Rule 56(c) mandates the entry of summary judgment against a party "who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and in which that party will bear the burden of proof at trial." *Id.* at 322, 106 S.Ct. at 2552-53; *Waldridge v. American Hoechst Corp.*, 24 F.3d 918, 920 (7th Cir. 1994). A scintilla of evidence in support of the non-moving party's position is not sufficient to oppose successfully a summary judgment motion; "there must be evidence on which the jury could reasonably find for the [non-movant]." *Anderson*, 477 U.S. at 250, 106 S.Ct. at 2511.

## III. DISCUSSION

### A. ERISA Plan

The defendant's first argument in favor of summary judgment is that no plan exists under ERISA. Defendant contends that the plaintiff, by failing to submit an actual, written copy of the health care plan, has not produced any proof that the plan actually exists. In response to defendant's argument, plaintiff has submitted the following items in an attempt to prove the existence of and defendant's participation in the plan: (1) the Affidavit of Audrey Basler, an account executive with HCC (including an itemized

statement of benefits provided to the defendant, an incident report filled out by the defendant regarding the accident, and a reimbursement agreement, the defendant's signing of which is in dispute); (2) a copy of the Subscriber's Service Agreement under the Michael Reese Health Plan, and a copy of the Certificate of Coverage under the Humana Health Care Plan; (3) the supplemental declaration of Audrey Basler; (4) the Affidavit of Barry Averill, former President of MRHP and Vice President of Humana (including an assignment agreement executed between Humana and HCC); (5) the Affidavit of Andrea Stallworth, Vice President of Marketing and Sales with MRHP; (6) the Affidavit of Henry S. Romano, Jr., General Counsel for HCC; (7) the Affidavit of David A. Belofsky, counsel for HCC in the State action; and, (8) the Declaration of Mary Ann Nolan, Manager of the Benefits Department of the University of Chicago hospital system, including a Summary Plan Description ("SPD").

Despite the fact that the plaintiff has submitted the MRHP Subscriber's Service Agreement, the MRHP Summary Plan Description, and the Humana Certificate of Coverage, defendant argues that no "plan" document has been produced, so a plan therefore does not exist. However, "the plan is a creature of statute. . . . it's an intangible. In this particular case, it's the document under which the plan was operated and that was the two certificates which I have referred to." (Def.'s Ex. C at 7.) Furthermore, according to the briefs, affidavits and declarations submitted by the plaintiff, including the Nolan Declaration, the terms and conditions of the plan were administered according to the certificates of coverage issued by MRHP and Humana, which have been submitted by the plaintiff.

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In determining whether an ERISA plan exists, courts have considered the surrounding circumstances. *See Phillips v. Brandess Home Builders, Inc.*, 1995 WL 591448 at *3 (N.D. Ill. Oct. 5, 1995); *Diak v. Dwyer, Costello & Knox, P.C.*, 33 F.3d 809, 811 (7th Cir. 1994) ("A plan need not be in writing to be covered by ERISA so long as the plan is a reality, meaning something more than a mere decision to extend benefits."). Although 29 U.S.C. § 1102 states that "every employee benefit plan shall be established and maintained pursuant to a written instrument," courts in the Seventh Circuit have held the writing requirement to be "flexible if the employees are aware of their rights and benefits under the plan." *Fietsam v. Connecticut General Life Insurance Company*, 1996 WL 89206 at *4 (N.D. Ill. Feb. 27, 1996). *See also Frascone v. General Pension Board of Continental Pension Plan et al.*, 761 F. Supp. 529, 535-536 (N.D. Ill. 1990).

In *Fietsam*, the plaintiff argued that there was no valid plan because there was no written instrument other than a Group Insurance Booklet, an expansive 89-page document which explained in detail the scope and terms of the plan. This court rejected that argument, reasoning that

> [c]learly, the Group Insurance Plan Booklet, which was distributed to Fietsam and all other Beltone employees contains extensive information about the benefits to which Beltone employees are entitled under the Plan. This court concludes that the written Booklet [is] sufficient to satisfy the writing requirement of 29 U.S.C. § 1102. The fact that a "formal plan" between

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> Beltone and CGLIC was never signed is irrelevant. This dispute is governed by ERISA and the Group Insurance Booklet attached as Exhibit A to Fietsam's complaint.

*Fietsam*, 1996 WL 89206 at *5.

Defendant's argument in the instant case mirrors that of plaintiff in *Fietsam*. Washington was issued a SPD, Subscriber's Service Agreement, and Certificate of Coverage. She was clearly of her rights and benefits under the plan. Furthermore, defendant stood by while her plan paid over $10,000 in benefits on her behalf, and now attempts to argue that a plan does not exist. This court finds that there was a plan.

It is true that once it is determined that ERISA covers a plan, its fiduciary and reporting provisions require the plan to be established pursuant to a written instrument. *Donovan v. Dillingham*, 688 F.2d 1367, 1372 (11th Cir. 1982). However, "[i]t is equally true that an employer's failure to meet an ERISA requirement does not exempt the plan from ERISA coverage." *Diak*, 33 F.3d at 812-813. Thus, this court finds that ERISA does not require a formal, written plan and rejects defendant's argument that there is no plan under ERISA.

B. Fiduciary Status

Having established that an ERISA plan exists in this case, this court now moves to the question of whether HHC is a fiduciary as defined by ERISA. ERISA provides that

"[a] civil action may be brought by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief. . . ." 29 U.S.C. § 1132(e)(1). Further, "a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, . . . or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan." *Id.* at § 1002(21)(A).

This court previously addressed the issue of fiduciary status in the defendant's motion to dismiss for lack of subject matter jurisdiction. *See Health Cost Controls of Illinois, Inc. v. Washington*, 1997 WL 461077 (N.D. Ill. Aug. 8, 1997). This court found, based on two affidavits submitted by the plaintiff, that HCC's status as an assignee for collection in pursuit of reimbursement claims is an activity necessary for the administration of the plan, and that HCC has discretion and control over the pursuit of such claims. The defendant moved to strike relevant portions of the two affidavits, which motions were denied. This court concluded that "[b]ecause HCC performs an administrative activity of the plan and has discretionary control over that activity, HCC is a fiduciary of the plan under 29 U.S.C. § 1002(21)(A). In addition, because HCC is a fiduciary, it may bring suit under the ERISA civil enforcement provisions." *Id.* at *6.

In arguing against summary judgment for the plaintiff, the defendant asserts again that HHC is "merely an assignee

of MRHP and Humana," and states that HHC's contention that it exercises discretionary authority and control is a "self serving legal conclusion." (Def.'s Response to Pl.'s Motion for Summary Judgment at 5). Defendants offer no evidentiary support for these allegations, except for a citation to a previous case in which defendant claims HCC was found not to qualify as an assignee. *See Health Cost Controls v. Skinner*, 845 F. Supp. 567 (N.D. Ill. 1994). However, defendant ignores the obvious distinctions between *Skinner* and the instant case. In *Skinner*, HCC alleged that it had been designated by HMO Illinois "to prosecute all of its rights to subrogation and reimbursement under the Plan." *Id.* at 568. In deciding to dismiss the action *sua sponte* on other grounds, the court noted that "HCC's self-description does not at all appear to qualify it as an ERISA fiduciary." *Id.* Unlike the situation here, the court in the *Skinner* action did not have the benefit of a properly-pleaded fiduciary claim, supported by evidentiary affidavits provided by the plaintiff.

Moreover, Federal Rule of Civil Procedure 56(e) states that "[w]hen a motion for summary judgment is made and properly supported as provided in this rule, an adverse party may not rest upon the mere allegations or denials of the adverse party's pleading, but the adverse party's response, by affidavits or as otherwise provided in this rule, must set forth specific facts showing that there is a genuine issue for trial." In other words, a party opposing a motion for summary judgment may not simply sit back and take pot shots at the moving party's evidence; the opposing party must present evidence of its own to create a genuine issue of material fact. Defendant has not met this burden, and this court therefore finds that HCC is a fiduciary as defined by ERISA.

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C. Terms of the Plan.

The Seventh Circuit has consistently held that uninsured motorist benefits are recoverable under an ERISA plan's subrogation agreement. *See Cutting v. Jerome Foods, Inc.*, 820 F. Supp. 1146 (W.D. Wisc. 1991), *aff'd*, 993 F.2d 1293 (7th Cir. 1993); *HealthChicago, Inc. v. Hernandez*, 1994 WL 447444 (N.D. Ill. Aug. 15, 1994). However, as defendant correctly points out, the courts in the cases cited by plaintiff were guided not by some overriding principle that uninsured motorist benefits are automatically subject to subrogation, but by the specific language and terms of the plans in question. Hence, it is this court's task to review the terms of the plan to determine if its subrogation provision applies to defendant's uninsured motorist recovery.

The language of the plan itself will determine which standard of review will apply to the court's construction of its terms. If a plan contains language that gives the plan's administrator discretion to interpret its terms, then a court may only apply an "arbitrary and capricious" standard, meaning that the court may reverse an administrator's interpretation only if that interpretation is unreasonable. *Cutting*, 933 F.2d at 1295-1296. If, on the other hand, the plan contains no such language, then a court must construe the terms of the plan *de novo*, applying principles of contract interpretation along with the federal common law of ERISA. *Allport v. Griffis*, 1997 WL 797647, at *6 (N.D. Ill. Dec. 17, 1997) (citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989)). Furthermore, the terms of the plan must be construed according to their plain, ordinary meaning. *Meredith v. Allsteel, Inc.*, 11 F.3d 1354, 1358 (7th Cir. 1993).

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The plan documents submitted by plaintiff contain no language granting interpretive discretion to a plan administrator; therefore, this court will review *de novo* the terms of the plan.

Three different subrogation provisions have been submitted by plaintiff — the MRHP Subscriber's Service Agreement (referred to by the plaintiff as the "Group Certificate"), the MRHP Summary Plan Description ("SPD"), and the Humana Certificate of Coverage. However, because Humana purchased MRHP's assets and interest in the reimbursement claim, and changed the terms of the subrogation provision, after Washington was injured and began receiving benefits, this court finds that HCC is bound to the terms of the MRHP provisions. This finding is consistent with the cases of the Seventh Circuit. In *Wahl v. Northern Telecom, Inc.*, 726 F. Supp. 235 (E.D. Wis. 1989), a beneficiary was injured in an automobile accident caused by a third party and received benefits from her Plan. After the injury and during treatment, the beneficiary's employer changed the terms of the subrogation provision of the Plan. The court held that

> although the terms of the Plan may be changed, equity considerations prohibit an employer from unilaterally amending a plan to eliminate coverage of a sickness or illness while a covered employee is in the middle of receiving payments for the illness. Thus, this court finds that the terms of the 1987 Plan are inapposite to the injury Jennifer incurred in the 1986 accident.

*Id.* at 242 n.5. *See also Filipowicz v. American Stores Benefit Plans Committee*, 56 F.3d 807, 814 (7th Cir. 1995) ("[S]ubsequent modifications to the plan do not affect the terms of the written plan in existence when insured died. . . . A later modification, even one that is retroactive, can have no effect on a beneficiary's claim to benefits."). Therefore, this court finds that the language contained in the Humana Certificate of Coverage is not relevant to the present case.

The Michael Reese Subscriber's Service Agreement ("Group Certificate") states:

> Medical services for injury caused by a third party are provided to a beneficiary. However, MRHP has the right to be reimbursed for the value of the services it has provided when a beneficiary receives payment from *a* third party. The beneficiary is required to cooperate with MRHP in regard to such injuries and payments. (emphasis added).

This court finds that the use of the definite article "a" to modify the second reference to third party indicates that the reference is to *any* third party, not necessarily the same third party that caused the injury. So, the plain and ordinary meaning of this provision of the Group Certificate is that MRHP is subrogated to reimbursement obtained from *any* third party, encompassing the third party that caused the injury as well as a third party that did not cause the injury.

At this point is helpful to define "third party." Plaintiff cites *Cutting*, *Hernandez*, and *Harmond v. Teamsters Joint*

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*Council No. 83 of the Virginia Health and Welfare Fund*, 795 F. Supp. 783 (E.D. Va. 1992), *aff'd*, 1 F.3d 1233 (4th Cir. 1993), in support of its position that uninsured motorist proceeds are within the scope of third party payments subject to subrogation. The language of the *Cutting* plan stated that the plan was subrogated to the rights of recovery from "any third party." *Cutting*, 820 F. Supp. at 1155. The court rejected plaintiff's argument that the plaintiff's insurer was not a "third party," reasoning that "the plain meaning of 'third party' includes any entity that is not a party to an agreement, that is, in this case, any party other than the defendant and plaintiff." *Id.* The *Hernandez* plan stated that subrogation applies to "payments made by or for, or attributable to the act or omission of, the third party responsible for the injury or illness." *Hernandez*, 1994 WL 447444 at *1. In finding that the subrogation clause entitled the plaintiff to recover the uninsured motorist benefits, the court held that uninsured motorist coverage payments were attributable to the action of the third party in the case, the uninsured motorist. Employing similar reasoning, the court in *Harmond* validated the health insurer's subrogation right when the plan claimed a right to "any benefits arising out of injury or illness . . . caused by the negligence or wrongful act of a third party." *Harmond*, 1994 WL 447444 at *5. Thus it is clear that the "third party" language may encompass an insured's own uninsured motorist auto insurance provider. However, the use of words like "any," "arising out of," and "attributable to" evinces a careful effort not to limit the potential sources of third party recovery. Cases in which such efforts were not made have not necessarily been decided in favor of subrogation.

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*Employers Health Insurance v. General Casualty Co. of Wisconsin*, 469 N.W.2d 172 (Wis. 1991), seems to be such a case. The Wisconsin Supreme Court, citing the language of the plan in that case, "[w]e shall be subrogated to your rights to recover . . . damages from a responsible third party," *Id.* at 175, held that "responsible third party" did not encompass the insured's own uninsured motorist policy. *Id.* at 176. However, *Employers Health* is not binding authority and, moreover, the Sixth Circuit case of *Wendy's International, Inc. v. Karsko*, 94 F.3d 1010 (6th Cir. 1996), speaks expressly to the contrary of the holding in *Employers Health*. The Sixth Circuit, reversing the District Court's opinion which quoted *Employers Health*, found that the defendant's uninsured motorist insurance company, as a third party, "may be 'responsible' for a 'loss' in the sense that it is legally obligated to the insured under certain circumstances." *Wendy's*, 94 F.3d at 1012-1013. Applying the arbitrary and capricious standard, the court concluded that Wendy's interpretation of the language of the plan as granting a subrogation right to the defendant's uninsured motorist coverage was reasonable. *Id.* ("While this is a rather broad use of the word 'responsibility,' it is certainly not irrational."). The *Wendy's* court went on, however, to state that

> [h]ad the SPD said that Wendy's had a right to monies collected only from the person who 'caused' the injury, this might be a closer case, since Nationwide certainly did not 'cause' the Karsko's loss. The phrase 'person responsible for the loss' is much more ambiguous, however, and is therefore subject to a broader range of interpretations.

*Id.* at 1013. Thus, because "responsible third party" is ambiguous, under an arbitrary and capricious standard the court deferred to the administrator's interpretation. The court hinted that, even under an arbitrary and capricious standard, let alone a *de novo* standard, Wendy's would have no right to subrogation under plan language that referred only to the third party that caused the injury.

Significantly, the language of the SPD differs slightly from the language of the Group Certificate. The SPD states: "HMO Illinois will provide medical services and treatment for injuries caused by a third party. You must, however, assign to HMO Illinois all rights to obtaining reimbursement from *the* third party for medical services provided by or through HMO Illinois." (emphasis added). This court finds that the use of the definite article "the" to modify the second reference to "third party" indicates that the reference is to the same third party mentioned earlier, or the third party that caused the injury. Hence, the plain and ordinary meaning of this provision is that HMO Illinois is subrogated only to reimbursement obtained from the third party that caused the accident, but not from a third party that did not cause the accident.

Even if this court found the terms of the SPD to be only ambiguous rather than limiting reimbursement to the third party causing the injury, under a *de novo* standard the same conclusion would be reached.[2] Relying on the well-established rule that an

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2. Under an arbitrary and capricious standard it could be argued that an administrator's interpretation of the subrogation provision as including uninsured motorist benefits would not be unreasonable; however, because such a standard is not applicable here, this court need not reach this issue.

ambiguous contract is construed against its drafter, the Seventh Circuit has held that "when the language of an insurance contract is ambiguous, the language must be construed in favor of the insured." *Hernandez*, 1994 WL 447444 at *6 (citing *Playboy Enterprises, Inc. v. St. Paul Fire and Marine Insurance Co.*, 769 F.2d 425, 428 (7th Cir. 1985).

In light of the apparently conflicting terms of the Group Certificate and SPD, HCC's right to subrogation of the money received by Washington through her uninsured motorist policy would seem to depend on which plan language is employed. Courts have found that when the terms of the SPD and the language of the plan are in conflict, the SPD controls. *See Williams v. Midwest Operating Engineers Welfare Fund*, 125 F.3d 1138, 1143 (7th Cir. 1997). But when the SPD is ambiguous or susceptible to the same interpretation as the plan, and the plan serves to clarify the language of the SPD, then the plan language may be used. *Mers v. Marriott International Group Accidental Death and Dismemberment Plan*, 1998 WL 228144 at *8 (7th Cir. Oct. 20, 1997). Although there is no tangible "plan" document in this case, the plaintiff has stated that the plan is operated under the terms of the Group Certificate. Therefore, for the purposes of determining which terms will control, the Group Certificate will be treated as the plan. And based on this court's *de novo* interpretation of the their terms, the SPD appears to conflict with, rather than clarify, the plan.

However, although there seems to be a conflict in language between the Group Certificate and SPD, defendant never refers to the language of the SPD. In defendant's briefs,

the contested language is that of the Group Certificate, which this court has interpreted to include within the scope of its subrogation provision uninsured motorists benefits. Hence, it is clear that defendant does not rely on the SPD language. Nevertheless, in spite of the fact that other circuits have held that a beneficiary can only seek to enforce conflicting SPD language if the beneficiary detrimentally relied on the SPD, courts in this Circuit do not require reliance where there is a conflict in the terms of the two documents. *See Allport v. Griffis*, 1997 WL 797647 (N.D. Ill. Dec. 17, 1997).

Reliance notwithstanding, all the terms of the SPD must be taken into account, not just the paragraph on subrogation. *Wise v. El Paso Natural Gas Company*, 1992 WL 129606 at *1 (W.D. Tex. Mar. 10, 1992) ("The law is clear that the summary plan description must be read as a whole. An employee cannot pick out one paragraph, page, or portion of the summary plan description and rely on that while ignoring the balance of the document."); *Sharron v. Almalgamated Insurance Agency Services, Inc.*, 704 F.2d 562, 566-567 (11th Cir. 1983) (To "focus on only one page of the summary [would] represent . . . an unrealistically narrow view of how a reasonably prudent employee would read and review this important document."). At the very beginning of the Michael Reese SPD, under the Introduction, there is a paragraph titled "About This Booklet." That paragraph reads, in part:

> This booklet has been prepared to inform you of the highlights of your coverage under the Michael Reese Health Plan . . . The provisions of the Plans are administered according to the Group Certificates . . . This booklet is not intended to

> interpret, extend or change the Plans in any way. In case of a conflict or discrepancy between this booklet and the actual Plan provisions, the Plan will govern your rights and benefits.

This section of the SPD incorporates the Group Certificate to explain the exact terms of subrogation. Thus, a reader is put on notice that he cannot rely on the terms of the SPD as the final word in describing, limiting, and explicating the terms of her Plan. This is consistent with the Seventh Circuit's interpretation of the role of the SPD, which mandates that it be "sufficiently accurate and comprehensive to reasonably apprise plan participants of their rights and obligations." *Mers*, 1998 WL 228144 at *9 (citing 29 U.S.C. § 1022). The Michael Reese SPD informs the reader that the plan will provide benefits when a participant is injured by a third party, that there are circumstances under which the plan is subrogated to recovery from such injury, and that the plan language and not necessarily the SPD language will govern the participant's obligations under such circumstances. Thus, when read as a whole, the SPD is not in conflict with, but rather is clarified by, the terms of the Group Certificate.[3] And this court finds that those terms require reimbursement of the $10,580.15 in benefits received by the defendant.

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3. It is disputed whether Washington signed the Reimbursement Agreement provided by HCC. However, this agreement expressly states that it is in accord with the reimbursement provision of the health plan, and that its signing does nothing to prejudice the participant's rights of recovery. For these reasons, the agreement could not be a basis for relief for either party in this case and is therefore immaterial to the present motions. *See Allport*, 1997 WL 797647 at *6-7.

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D. Affirmative Defenses

Washington asserts a long list of affirmative defenses to HCC's motion, many of which were disposed of in defendant's earlier motion to dismiss. *See Health Cost Controls v. Washington*, 1996 WL 252552 (N.D. Ill. May 10, 1996). Specifically, defendant's assertion of Res Judicata, Collateral Estoppel, Colorado River doctrine, 28 U.S.C. § 1447(d), and Failure to State a Claim were all denied. Further, the arguments defendant makes in its assertion of Lack of Subject Matter jurisdiction were also disposed of by this court in its response to defendant's Failure to State a Claim defense. This court will not rehash these issues here, but rather refers defendant to its earlier Memorandum Opinion and Order.

Defendant also asserts a defense which it improperly labels "Impermissible Claim Splitting." Claim Splitting involves a party dividing a single cause of action into separate parts and then proceeding on a multiplicity of suits. 1A C.J.S. *Actions* § 177 (1985). This has clearly not happened in the instant case. The crux of defendant's argument is that plaintiff may not proceed on the same claim concurrently in state and federal court. This argument is actually the same one defendant made in its affirmative defense of Colorado River doctrine which, due to the exclusively federal nature of the claim, has already been disposed of by this court.

The remaining affirmative defenses are contract-based claims, which defendant asserts based on the assertion that plaintiff agreed that the case would be litigated exclusively in the Circuit Court of Cook County, Illinois. The record is

absolutely devoid of any evidence to support the existence of such an agreement.

In the affidavit of Larry R. Barezky, defendant's attorney, the affiant states that he agreed with plaintiff's attorney to place the disputed amount into an escrow account pending final determination of the dispute. (Barezky Aff. ¶8.) Affiant further states that they also agreed that his office would file a suit for declaratory judgment in state court, and refers to an exhibit containing correspondence between the attorneys for evidentiary support. Whether this alleged agreement would constitute a contract or even a promise upon which an estoppel claim could be based, let alone a contract or promise that the dispute would be litigated exclusively in state court, is doubtful. But the court need not address this issue. The correspondence defendant cites consists of a letter asking Christopher Michas, plaintiff's attorney, to endorse the check to be place in escrow "until the Court makes a final determination on what monies, if any is owed. . ." Michas' reply refers to the enclosed endorsed check, and states that "[f]urther to our agreement, I understand that this check will be deposited in an interest bearing account pending final determination on our dispute." From this exchange, defendant extrapolates an agreement that the dispute would be litigated exclusively in state court, and a waiver on plaintiff's part to sue. Even viewing the evidence in a light most favorable to the defendant, this court is unable to locate such an agreement within the correspondence.

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D. Attorney's Fees

In cases brought under ERISA, "the court in its discretion may allow a reasonable attorney's fee and costs of action to either party." 29 U.S.C. § 1132(g)(1). A five-factor test has been established by the Seventh Circuit in order to determine whether to award attorney's fees to the prevailing party:

> (1) the degree of the offending party's culpability or bad faith;
>
> (2) the offending party's ability to satisfy personally an award of attorney's fees;
>
> (3) whether such an award will deter others from the same actions:
>
> (4) the amount of benefit conferred by the action on all the members of the retirement plan;
>
> (5) the relative merits of the parties' positions.

*Khoury v. Cook Associates, Inc.*, 1996 WL 745444 at *1 (N.D. Ill. Dec. 27, 1996). The above test is typically employed when a plaintiff prevails. *Id.* When a defendant prevails, a more general approach is taken, entitling the party to attorney's fees "unless the court finds that the position of the losing party was 'substantially justified' or that 'special circumstances make an award unjust.' " *Meredith v. Navistar International Transportation Corp.*, 935 F.2d 124, 128 (7th Cir. 1991). Notwithstanding these two approaches, "the bottom-line question is essentially the same: was the losing

party's position substantially justified and taken in good faith, or was that party simply out to harass its opponent?" *Id.* Finally, there is a well-established presumption in the Seventh Circuit against awarding attorney's fees to prevailing ERISA plaintiffs. *Davidson v. Canteen Corp.*, 957 F.2d 1404, 1409-1410 (7th Cir. 1992). Since the plaintiff has prevailed in the instant case, this court will apply the five-factor test.

The first factor does not support the awarding of attorney's fees. The number of cases this court has reviewed similar to the instant case is an indication of the complexity of the ERISA statute and the reasonableness of a defendant's misunderstanding of the concept of subrogation. Thus, there is no indication that the defendant's position was in bad faith.

The second factor also appears to be in the defendant's favor. The amount of time this case has taken up over the last several years makes for an extremely high burden on an individual to personally pay attorney's fees.

Nor does the third factor support the awarding of fees. Because the plan language in dispute in the instant case is no longer in existence, and has been replaced by new, more precise language, it is unlikely that awarding attorney's fees to the plaintiff, on top of a decision in plaintiff's favor, would have a deterrent effect on potential future plaintiffs.

The fourth factor favors an award of fees. The decision in this case prevents other plan members from footing the bill for medical benefits which should have been paid by an individual member's auto insurance company. *See Dimensions Medical Center, Ltd. v. Aetna Life Insurance*

*Company*, 1997 WL 534548 at *3 (N.D. Ill. Aug. 26,1997). Moreover, an award of fees would also prevent the health plan from passing the costs and risks of litigation on to the plan members. *See Id.*

Finally, for reasons mirroring those in factor one, the fifth factor does not support an award of fees. This court believes that the position of both parties had merit.

In view of the foregoing reasons, the five-factor test does not support the awarding of attorney's fees to the plaintiff. Although the fourth factor weighs in favor of such an award, the balance of the factors outweigh it. It follows, then, that the defendant's position was "substantially justified and taken in good faith," and the defendant was not "simply out to harass its opponent" Moreover, in light of the presumption against awarding fees to prevailing plaintiffs, an award in the instant case is not justified.

## IV. CONCLUSION

For the foregoing reasons, the plaintiff's motion for summary judgment is granted, with the exception that plaintiff's request for the award of attorney's fees is denied. Defendant's motion for summary judgment is denied.[4] Judgment will be entered in favor of the plaintiff.

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4. Defendant failed to file a Local Rule 12(M) statement in support of her motion for summary judgment. The consequence of this omission is explicit under the Rules: "Failure to submit . . . constitutes grounds for denial of the motion." Rule 12(M). Defendant argues that its motion is "based solely on legal principles. . . . A

(Cont'd)

*Appendix B*

Enter:

s/ David H. Coar
s/ David H. Coar
United States District Judge

dated: August 7, 1998

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(Cont'd)
Rule 12(M) statement identifying factual issues would do nothing to streamline the summary judgment process." This court reminds defendant that compliance with Rule 12(M) is not discretionary; however, defendant's failure to follow procedure is not fatal here, because the facts by this stage of the dispute have been thoroughly laid out before the court. Defendants are admonished to comply with all local rules in the future.

## APPENDIX C — ORDER OF THE APPELLATE COURT OF ILLINOIS, FIRST JUDICIAL DISTRICT DATED DECEMBER 16, 1997

No. 1-96-0770

IN THE APPELLATE COURT
OF ILLINOIS
FIRST JUDICIAL DISTRICT

VALERIE WASHINGTON,

Plaintiff-Appellee,

v.

HUMANA HEALTH PLAN, INC., MICHAEL REESE HEALTH PLAN, INC., HEALTH COST CONTROLS OF ILLINOIS, INC., and HEALTH COST CONTROLS OF AMERICA, INC.,

Defendants-Appellants.

Appeal from the Circuit Court of Cook County.

No. 94-CH-8133

Honorable Lester D. Foreman, Judge Presiding.

ORDER

Plaintiff, Valerie Washington, brought this action in the circuit court of Cook County against defendants, Humana Health Plan, Inc. (hereinafter Humana plan), Michael Reese

Health Plan (hereinafter Reese plan), Health Cost Controls of Illinois, Inc., and Health Cost Controls of America, Inc. (hereinafter collectively as HCC), seeking a declaratory judgment that the reimbursement provisions of defendants' health benefit plans did not apply to the uninsured motorist benefits provided by her automobile insurance policy. Defendants filed a motion to dismiss plaintiff's action pursuant to sections 2-615 and 2-619 of the Code of Civil Procedure (Ill. Rev. Stat. 1989, ch. 110, pars. 2-615, 2-619 (now 735 ILCS 5/2-615, 2-619 (West 1996)).) The circuit court denied defendants' motion finding that plaintiff's complaint stated a cause of action and that her claim was not preempted by section 514 of the Employment Retirement Income Security Act of 1974, as amended (hereinafter ERISA). However, the circuit court did certify for interlocutory review the question of whether plaintiff's claims are preempted by Federal law. Defendants now bring that question before this court pursuant to Supreme Court Rule 308 (155 Ill. 2d R. 308).

For the following reasons, we affirm.

Plaintiff was injured in an automobile accident caused by an uninsured motorist on May 25, 1989. At the time of the accident, plaintiff was a member of the Reese plan and had an automobile insurance policy issued by Allstate Insurance Company (hereinafter Allstate) that provided uninsured motorist benefits. The Reese plan's certificate of coverage contained the following provision:

"THIRD PARTY LIABILITY

Medical services for injury caused by a third party are provided to a beneficiary. However [the Reese

> plan] has the right to be reimbursed for the value of the services it has provided when a beneficiary receives payment from a third party. The beneficiary is required to cooperate with [the Reese plan] in regard to such injuries and payments."

In June 1989, the Reese plan asserted a right of reimbursement for medical services rendered to plaintiff for injuries received in connection with the automobile accident.

Sometime between 1989 and 1992, the Reese plan merged with the Humana plan; thus, plaintiff became a member of the Humana plan. The Humana plan's certificate of coverage contained the following provision:

> "PROVISIONS FOR SUBROGATION
>
> This provision applies when another party (person or organization) is or may be considered responsible for payment because of a member's injury or sickness for which benefits under the Group Plan have been provided. To the extent of such services provided, we are subrogated to all rights of recovery the member has against that other party and we may assert such rights independent of the member. Also, if the member has obtained or obtains a court judgment, settlement, or other monetary recovery from another party, because of the injury or sickness, we are subrogated to the proceeds of the third-party payment to the extent of benefits

> provided. If a third-party payment is made, we shall have first priority, over the member or any other party, to receive from the third-party payment reimbursement of the benefits we have provided. * * * "

The Humana plan asserted a right of reimbursement for services provided to plaintiff in connection with the automobile accident.

On May 12, 1994, an arbitration panel directed Allstate to pay plaintiff $60, 000 in uninsured motorist benefits. Since defendants asserted a right to reimbursement in the amount of $10,500.15, the award was issued in two checks, one made payable to plaintiff in the amount of $49,419.85, and one made payable to plaintiff and HCC who was responsible for administering and interpreting the plans in the amount of $10,500.15.

On September 8, 1994, plaintiff filed an action in the circuit court of Cook County seeking a declaratory judgment that defendants had no right of reimbursement with respect to the arbitration award based on uninsured motorist benefits. Specifically, plaintiff contends that because the payment was not received from the third party responsible for the injuries, she has no obligation to reimburse defendants for medical services rendered. On October 12, 1994, defendants filed a notice of removal from the circuit court to the United States District Court for the Northern District of Illinois, asserting that the health plans are employee welfare benefit plans and thus are preempted by section 514 of ERISA. The district court found no "substantial" question of Federal law and,

thus, no Federal question jurisdiction. The district court then remanded the case to the circuit court of Cook County.

On August 21, 1995, defendants filed a motion to dismiss plaintiff's claim pursuant to sections 2-615 and 2-619 of the Code of Civil Procedure. Defendants argued that plaintiffs complaint failed to state a cause of action and that the claim was preempted by ERISA. On January 9, 1996, the trial court denied defendants' motion to dismiss holding that plaintiff had stated a cause of action and that Federal preemption did not apply. On February 22, 1996, the trial court certified the following question for interlocutory review: whether the claims asserted in the Complaint are preempted by section 514 of ERISA. This court accepted the question for interlocutory appeal on January 21, 1997. Proceedings in the circuit court have been stayed pending resolution of the instant appeal.

The Supremacy Clause of the United States Constitution states that the Federal Constitution, statutes and treaties "shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const. art. VI, cl. 2. Congress' intent to preempt a State law may be explicitly stated within the language of the statue or implicitly contained in its structure and purpose. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Sholtens v. Schneider*, 173 Ill. 2d 375, 379 (1996). The U.S. Supreme Court has stated that it never assumes lightly that Congress has derogated State regulation, but instead addresses claims of preemption with the assumption that Congress does not intend to supplant State law. *New*

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*York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company*, 514 U.S. 645, 654 (1995).

Section 514 (a) of ERISA provides in pertinent part that:

> "the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a) (1982).

The Supreme Court has held that a law "relates to" an employee benefit plan if it has "a connection with or reference to such a plan." *Shaw*, 463 U.S. at 96-97. However, in *New York Conference*, the Court recognized that the phrase "relates to" cannot be taken to its most expansive interpretation or such words of limitation would be read as a mere sham. *New York Conference*, 514 U.S. at 655. The Court therefore determined that, when considering questions of preemption, we must look not only to the language but to the structure and purpose of the statute as well. *New York Conference*, 514 U.S. at 656; *Sholtens*, 173 Ill. 2d at 383. After examining section 514, the Supreme Court has consistently found that its purpose is to "avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.". *New York Conference*, 514 U.S. at 657; *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990). Moreover, the Court has determined that section 514 indicates Congress' intent to establish the regulation of such plans "as exclusively a Federal concern." *New York Conference*, 514 U.S. at 656. However, despite this finding, where a State law has only a

tenuous, remote or peripheral connection with an employee benefit plan, Federal preemption will not occur. *Shaw*, 463 U.S. at 96-97; *New York Conference*, 514 U.S. at 661.

In the present case, defendants argue that our State law rules of contract construction refer to and have a connection with the employee benefit plan and, thus, Federal preemption should occur. Plaintiff, on the other hand, contends that no specific State law mandating employee benefit plans or plan administration is at issue here. Rather, according to plaintiff, rules of general applicability, such as the rules of contract construction, are not the type of laws that Congress intended to preempt. See *Sholtens*, 173 Ill. 2d at 385-86.

In *Sholtens*, the Illinois Supreme Court considered whether section 514 of ERISA preempts application of the common fund doctrine. In its analysis, the court found that the common fund doctrine is a common law rule of general application which does not single out or expressly refer to ERISA plans. *Sholtens*, 173 Ill. 2d 385. As such, the court recognized that it is similar to other rules of general applicability which the U.S. Supreme Court has held affect employee benefit plans in too tenuous or remote a manner to warrant Federal preemption. *Sholtens*, 173 Ill. 2d at 386. We find this analysis directly on point. Common law rules of contract construction are also rules of general applicability and in no way refer to employee benefit plans. Accordingly, we believe the rules of contract construction have too tenuous or remote an affect on employee benefit plans to warrant a finding that they "relate to" the plan.

*Appendix C*

In addition to finding that the rules of contract construction do not "relate to" employee benefit plans, we must also consider Congress' intent in enacting section 514 in order to determine whether Federal preemption should occur. *New York Conference*, 514 U.S. at 656; *Sholtens*, 173 Ill. 2d at 386. Specifically, "[w]e must inquire whether preemption would serve the basic purpose of section 514 (a), namely, 'to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.' " *Sholtens*, 173 Ill. 2d at 386 quoting *New York Conference*, 514 U.S. at 657.

Defendants contend that applying State court rules of contract construction will frustrate the basic purpose of section 514(a). According to defendants, since plaintiff's claim arises directly out of the subrogation clause of the employee benefit plan, any construction of the plan's terms will alter the relationships and agreements formulated among principal ERISA entities. Moreover, defendant argues that applying State law rules of contract construction to terms of an ERISA plan will subject plan providers to different liability conditions from State-to-State. We disagree with defendant's arguments.

Contrary to defendants' suggestion, application of the rules of contract construction to the terms of plaintiff's employee benefit plan will not alter the relationships or agreements between the parties. Rather, the rules of contract construction can only help to shed light on the meaning of the reimbursement provisions contained within the plan. The effect of applying these rules will be only an interpretation of the terms already existing within the plan; it will not be a

modification of those terms or of the relationships between the parties. Moreover, common law rules of contract construction are not unique to Illinois; similar rules exist among virtually every State as well as within the Federal system. Although creating a uniform regulation of employee benefit plans is the basic purpose of section 514(a), we do not believe that it was Congress' intent to preempt the entire common law. Therefore, we find that there is not a sufficient connection between the common law rules of contract construction and the employee benefit plan at issue here to warrant Federal preemption.

Accordingly, our answer to the Rule 308 question certified by the circuit court is that the claims asserted in the complaint are not preempted by Section 514 of ERISA.

Affirmed and remanded.

TULLY, J., with RAKOWSKI and FROSSARD, JJ., concurring.

## APPENDIX D — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT DATED MAY 18, 1995

**UNITED STATES COURT OF APPEALS**
For the Seventh Circuit
Chicago, Illinois 60604

May 18, 1995

Before

Hon. RICHARD A. POSNER, Chief Judge

Hon. WILLIAM J. BAUER, Circuit Judge

Hon. MICHAEL S. KANNE, Circuit Judge

No. 95-2075

IN THE MATTER OF:
HUMANA HEALTH PLAN, INCORPORATED, MICHAEL REESE HEALTH PLAN, INCORPORATED, HEALTH COSTS CONTROLS OF ILLINOIS, INCORPORATED, et al.,
Petitioners.

Appeal from the United States District Court for the Northern District of Illinois, Eastern Division.

No. 94 C 6179

George W. Lindberg, Judge.

*Appendix D*

The following is before the court:

1. DEFENDANTS' PETITION FOR A WRIT OF MANDAMUS TO DIRECT THE DISTRICT COURT TO VACATE ITS ORDER OF APRIL 21, 1995 REMANDING THIS CASE TO THE CIRCUIT COURT OF COOK COUNTY, filed on May 5, 1995, by counsel.

2. DEFENDANTS' AMENDED PETITION FOR A WRIT OF MANDAMUS, filed on May 8, 1995, by counsel.

3. PLAINTIFF'S RESPONSE TO DEFENDANTS' PETITION FOR A WRIT OF MANDAMUS, filed on May 9, 1995, by counsel.

4. MOTION FOR LEAVE TO SUPPLEMENT DEFENDANTS' AMENDED PETITION FOR A WRIT OF MANDAMUS WITH COPIES OF PLAINTIFF'S MOTION TO REMAND, DEFENDANTS' RESPONSE THERETO AND HCC'S COUNTERCLAIM FILED IN THE DISTRICT COURT, filed on May 10, 1995, by counsel.

IT IS ORDERED that #4 is GRANTED. Defendants-Petitioners' petition for a writ of mandamus, as amended pursuant to this court's May 8, 1995 order, is DENIED. *See In re Continental Casualty Co.*, 29 F.3d 292 (7th Cir. 1994) ; *See also Nutter v. Monongahela Power Co.*, 4 F.3d 319 (4th Cir. 1993); *Soley v. First National Bank of Commerce*, 923 F.2d 406 (5th Cir. 1991).

*Appendix D*

IT IS FURTHER ORDERED that the temporary stay entered on May 8, 1995 is hereby VACATED.

## APPENDIX E — MEMORANDUM OPINION AND ORDER OF THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION DATED APRIL 20, 1995

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

No. 94 C 6179

Judge Lindberg

VALERIE WASHINGTON,

Plaintiff,

-vs-

HUMANA HEALTH PLAN, INC., a foreign corporation, MICHAEL REESE HEALTH PLAN, INC., an Illinois health service plan corporation, HEALTH COST CONTROLS OF ILLINOIS, INC., an Illinois corporation, and HEALTH COST CONTROLS OF AMERICA, INC., an Illinois corporation,

Defendants.

MEMORANDUM OPINION AND ORDER

Following an automobile collision with an uninsured motorist, a panel of arbitrators awarded plaintiff Valerie Washington $60,000 for her injuries from Allstate Insurance Company based on her uninsured motorist coverage benefits.

Washington received treatment costing $10,500.15 under a health benefit plan (the "Plan") sponsored by the University of Chicago. Defendants (hereinafter collectively referred to as "Humana") are alleged to be current or former owner-operators or administrators of the Plan. Humana claims a right under the terms of the Plan to reimbursement for the cost of Washington's treatment. Washington brought this action in the Circuit Court of Cook County seeking a declaratory judgment that she is not required under the terms of the Plan to reimburse Humana for the cost of the treatment she received. Humana removed this case to federal district court. In the notice of removal, Humana asserted that the Plan is an employee welfare benefit plan as defined in section 3(l) of the Employee Income Retirement Security Act of 1974, as amended ("ERISA"). Humana argued that Washington's state law claims are preempted by section 514 of ERISA, 29 USC § 1144, and that her pleaded claims, to the extent they are legally cognizable, exclusively arise under ERISA, specifically 29 USC § 1132(a)(1). Washington has now moved to have this case remanded to state court.

Under the federal removal statute,

> any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending.

28 USC § 1441(a). The district courts "shall have original jurisdiction of all civil actions arising under the Constitution,

laws, or treaties of the United States." 28 USC § 1331. A case "arises under" the laws of the United States only if the plaintiff's well-pleaded complaint raises issues of federal law. *Metropolitan Life Ins. Co. v Taylor*, 481 US 58, 63 (1987). In other words,

> "[W]hether a case is one arising under the Constitution or a law or treaty of the United States, in the sense of the Jurisdictional statute, . . . must be determined from what necessarily appears in the plaintiff's statement of his own claim in the bill or declaration, unaided by anything alleged in anticipation of avoidance of defenses which it is thought the defendant may interpose."

*Franchise Tax Board v Construction Laborers Vacation Trust*, 463 US 1, 10 (1983) (quoting *Taylor v Anderson*, 234 US 74, 75-76 (1914)). Thus, for example, under this doctrine, which is known as the "well-pleaded complaint" rule, a complaint that raises only state law causes of action could not be removed to federal court on the basis of an answer that pleaded the defense of federal preemption. *Franchise Tax Board*, 463 US at 13-14.

The "complete preemption" doctrine is an exception to the well-pleaded complaint rule. Under this doctrine, a state cause of action is recharacterized as a federal cause of action when Congress "so completely pre-empt[s] a particular area that any civil complaint raising this select group of claims is necessarily federal in character." *Taylor*, 481 US at 63-64. The Court in *Taylor*, after examining the legislative history of ERISA, concluded that "Congress has clearly manifested

an intent to make causes of action within the scope of the civil enforcement provisions of § 502(a) [of ERISA] removable to federal court." *Id.* at 66. Thus, in resolving the motion for remand, the court must determine whether Washington's state cause of action comes within the scope of the civil enforcement provisions of § 502(a) and is thus completely preempted. If the court determines that Washington's claim is completely preempted then presumably it is substantively preempted as well under 29 USC § 1144(a). See, e.g., *Lister v. Stark*, 890 F2d 941, 943-44 & n 1 (7th Cir 1989), *cert. denied*, 498 US 1011 (1990).

Section 502(a) of ERISA (codified at 29 USC § 1132(a)) provides:

> A civil action may be brought —
>
> (1) by a participant or beneficiary —
>
> . . . .
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his right to future benefits under the terms of the plan.

Humana argues that Washington's claim falls within the scope of § 1132(a)(1)(B).[1] Washington disagrees. She argues that, because she has already received benefits under the Plan,

---

1. Section 502(a) also provides that a civil action may be brought

(Cont'd)

her cause of action is neither one to "recover benefits due to [her] under the terms of [her] plan," nor one to "clarify [her] right to future benefits under the terms of the plan." She also argues that she is not trying to "enforce [her] rights under the terms of the plan," because she simply seeks a declaratory judgment that Humana has no right to reimbursement.

The court believes that, through her declaratory judgment action, Washington is not trying to "recover benefits." Moreover, because she has already received benefits under the Plan, one cannot say that she is trying to "clarify [her] right to future benefits." It is a closer question, however, whether she is trying to "enforce [her] rights under the terms of the plan." The parties have been unable to cite any case directly on point. Thus, in order to resolve this question, it is necessary to consider the precise nature of Washington's action.

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(Cont'd)

> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

However, because § 502(a)(3) authorizes a civil action only for an injunction (which clearly is not involved here) or other equitable relief, it does not apply to Washington's declaratory judgment action, which is more legal in nature than equitable. See *Gulf Life Ins. Co. v Arnold*, 809 F2d 1520, 1523 (11th Cir 1987); *Transamerica Occidental Life Ins. Co. v DiGregorio*, 811 F2d 1249, 1251-52 (9th Cir 1987).

*Appendix E*

Washington has received benefits under the terms of the Plan. She seeks nothing else from the Plan. She desires to maintain the status quo. She is suing for a legal determination that she is not required under the terms of the Plan to reimburse the Plan for monies collected from Allstate. There is authority from two other circuits, although not precisely on point, that nevertheless strongly suggests that a declaratory judgment action such as Washington's is not an enforcement action. See *Gulf Life Ins. Co. v Arnold*, 809 F2d 1520, 1523 (11th Cir 1987) (holding that declaratory Judgment action by ERISA fiduciary to establish that it was not liable to a plan participant for severance benefits did not arise under § 1132(a)(3) because it was not a suit to "enforce" the terms of the plan); *Transamerica Occidental Life Ins. Co. v DiGregorio*, 811 F2d 1249, 1251-53 (9th Cir 1987) (holding that declaratory judgment action by ERISA insurer to establish that its policy did not provide double indemnity to a particular insured did not arise under § 1132(a)(3) because it was not a suit to "enforce" the terms of the plan). But see *Prendergast v Health Cost Controls*, No. 94 C 3501, 1994 US Dist LEXIS 11386 (ND Ill Aug 11, 1994). The Seventh Circuit recently cited *Gulf Life* and *Transamerica* for the proposition that a Plan fiduciary, who brings an action for a declaratory judgment that a participant is not entitled to certain benefits, does not thereby seek to "enforce" any provision of ERISA or the Plan. See *Massey Ferguson Division of Varity Corp. v. Gurley*, No. 94-3465, 1995 US App LEXIS 6425, at *3 (7th Cir Mar 30, 1995). Ultimately, however, this statement must be considered dictum because the court decided that it lacked appellate jurisdiction. *Id.* at *7. Nevertheless, based on all the above authorities, it appears that Washington's suit is not one to "enforce" her rights under the terms of the Plan.

*Appendix E*

The Seventh Circuit's decision in *Winstead v J.C. Penney Co.*, 933 F2d 576 (7th Cir 1991), is not to the contrary. *Winstead* involved a declaratory judgment action by fiduciaries of one ERISA plan against another ERISA plan to establish the plans' respective liabilities. The district court held that it lacked jurisdiction because the suit was not one to "enforce" the terms of the plan. *Winstead v J.C. Penney Co.*, 740 F Supp 1358, 1361-63 (ND Ill 1990). On appeal, the Seventh Circuit reversed, holding that the district court had jurisdiction under the terms of § 1132(a)(3). The court concluded: "[W]e do no semantic violence to section 1132(a)(3) when we interpret it to allow an ERISA plan to bring a declaratory judgment action to determine the extent of its liability, and we promote the goals of ERISA by that interpretation." *Winstead*, 933 F2d at 580. However, the court believes *Winstead* is limited to the context of coordinating related plans' conflicting or overlapping provisions. See *Gurley*, 1995 US App LEXIS 6425, at *3.[2]

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2. Citing *Pilot Life Ins. Co. v Dedeaux*, 481 US 41, 53 (1987), the court in Winstead also stated that "ERISA expressly authorizes participants and beneficiaries . . . to bring [declaratory judgment suits] in federal court." *Winstead*, 933 F2d at 578. This statement is dictum because the suit in Winstead was one by a fiduciary, not a participant or beneficiary. Moreover, the Court in *Pilot Life* stated that relief under § 1132(a) "may take the form of . . . a declaratory judgment on entitlement *to benefits*." *Pilot Life* 481 US at 53 (emphasis added). Here, Washington seeks no benefits; she has already received benefits, and she merely seeks to avoid reimbursing Humana the proceeds from her arbitration award. In any event, that part of *Pilot Life* relied upon is dictum because *Pilot Life* involved a claim for damages, not a claim for declaratory relief. The court is not bound by dictum based on inapplicable dictum.

Nor is *Health Cost Controls v Skinner*, 44 F3d 535 (7th Cir 1995), to the contrary. In *Skinner*, a plan fiduciary brought an action under § 502(a)(3) of ERISA for compensatory damages. The district court, sua sponte, dismissed the action for lack of subject matter jurisdiction. The Seventh Circuit reversed, on the ground that when a federal statute upon which a claim is premised is interpreted to be inapplicable, the appropriate course is to assume the existence of jurisdiction and to determine the merits of the claim pursuant to Rule 12(b)(6). 44 F3d at 537. This reasoning in *Skinner* does not apply in the removal context where the burden is on the party seeking removal to establish federal jurisdiction. See *Jones v General Tire & Rubber Co.*, 541 F2d 660, 664 (7th Cir 1976).

The court concludes that Washington's declaratory judgment action is not one to "enforce" her rights under the terms of the Plan. Moreover, because her suit is neither one to "recover benefits" nor one to "clarify [her] right to future benefits," it does not arise under § 1132(a)(1).

Humana argues that the remedy Washington seeks is irrelevant to this court's jurisdiction. Humana directs the court's attention to the following language in the Supreme Court's decision in *Pilot Life*:

> The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.

*Pilot Life*, 481 US at 54. Based on this language, Humana argues that the question of whether ERISA provides Washington with the remedy she seeks — a declaratory judgment — is not germane to the issue of whether this court has jurisdiction over this cause. The court finds this argument somewhat perplexing. If the quoted language from *Pilot Life* is to be read so as to prohibit Washington from bringing a declaratory judgment action based on state law, it is because "Congress rejected [such a remedy] in ERISA." However, if that is the case, then Washington cannot seek this remedy in federal court either, and thus there would be no removal jurisdiction. In any event, *Pilot Life* is distinguishable on the ground that it did not involve removal from state court to federal court. In contrast, *Taylor did* involve the issue of removal jurisdiction, and there the Court clearly indicated that the causes of action that are removable are those that fall within the scope of the civil enforcement provisions of § 502(a) of ERISA. *Taylor*, 481 US at 64-66. Section 502(a) differentiates among various causes of action by the relief that is sought. Therefore, contrary to Humana's argument, Washington's chosen remedy *is* germane to the issue of this court's removal jurisdiction.

Humana also argues that removal is proper because this court has "original jurisdiction under . . . the federal common law." Notice of Removal at 2; see also Defendants' Response Memorandum at 7-8. None of the cases cited by Humana support this position. In *FMC Corp. v Holliday*, 498 US 52 (1990), an operator of an ERISA plan brought an action in federal court based on diversity of citizenship. The plan sought a declaration that one of the plan's participants was contractually required to reimburse the plan for medical

expenses the plan paid on her behalf after she obtained a settlement from the party who caused her injuries. The district court granted summary judgment to the plan participant on the ground that state anti-subrogation law prevented the plan from enforcing its contractual reimbursement provision. The Third Circuit affirmed the district court's decision. The Supreme Court reversed, holding that the state anti-subrogation law was preempted by ERISA. *Id.* at 65. The Court did not consider whether removal jurisdiction could be based on federal common law; indeed, the case did not even involve removal jurisdiction. *Baxter v Lynn*, 886 F2d 182 (8th Cir 1989), also cited by Humana, did involve removal from state court to federal court. However, on appeal the Eight Circuit discussed two issues: Whether the common law restrictions on subrogation were preempted, and after finding that they were, whether subrogation was appropriate under the terms of the plan. The Eighth Circuit did not discuss the district court's removal jurisdiction. Finally, Humana relies on *Dugan v Nickla*, 763 F Supp 981 (ND Ill 1991). In that case, an ERISA plan brought suit in federal court against one of its participants because of a dispute over the amount of money owed to the plan under a subrogation provision in the plan. The district court determined that it had subject matter jurisdiction under 28 USC § 1331 because the claim was based on federal common law. *Id.* at 982-83. *Dugan* is not controlling because it did not consider whether federal common law can provide removal jurisdiction in the face of the well-pleaded complaint rule.

The Supreme Court's reasoning in several removal cases supports the view that federal common law does not provide a basis on which to find removal jurisdiction. In *Franchise*

*Tax Board v Construction Laborers Vacation Trust*, 463 US 1 (1983), the Court held that ERISA preemption, without more, does not convert a state claim into an action arising under federal law. *Id.* at 25-27. The Court left open the possibility that a cause of action that fell within the scope of § 501(a) of ERISA might fall within the complete preemption doctrine as described in *Avco Corp. v Aero Lodge No. 735, Int'l Ass'n of Machinists*, 390 US 557 (1968). The Court addressed that unresolved issue in *Metropolitan Life Ins. Co. v Taylor*, 481 US 58 (1987). In *Taylor*, the Supreme Court considered whether state common law causes of action asserting improper processing of a claim for benefits under an ERISA plan were not only preempted by ERISA (as found in the companion case of *Pilot Life*, *supra*), but also displaced by ERISA's civil enforcement provision, § 502(a)(1)(B), to the extent that complaints filed in state courts purporting to plead such state law causes of action are removable to federal court under 28 USC § 1441(b). The Court noted that

> [i]n the absence of explicit direction from Congress, this question would be a close one. . . . Even with a provision such as § 502(a)(1)(B) [29 USC § 1132(a)(1)(B)] that lies at the heart of a statute with the unique pre-emptive force of ERISA, however, we would be reluctant to find that extraordinary pre-emptive power, such as has been found with respect to § 301 of the LMRA (Labor Management Relations Act], that converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule.

*Id.* at 64-65 (citations omitted). Despite these reasons for caution, the Court noted the parallel language in the jurisdictional subsections of ERISA and the LMRA. In addition, upon examining the legislative history, the court found a "clear intention to make § 502(a)(1)(B) suits . . . federal questions for purposes of federal court jurisdiction in like manner as § 301 of the LMRA." *Id.* at 66. The Court concluded that, although a preemption defense does not, in most cases, create removal jurisdiction, "[i]n this case . . . Congress has clearly manifested an intent to make causes of action within the scope of the civil enforcement provisions of § 502(a) removable to federal court." *Id.* Given this detailed and complex analysis to ascertain the conditions under which removal jurisdiction exists, the court does not believe that any cause of action that implicates the federal common law of ERISA can be removed to federal court. If that were the case, then there would have been no need for the Supreme Court to so carefully analyze and compare § 501(a) of ERISA and § 301 of the LMRA to determine the existence of removal jurisdiction.

Finally, the court will address certain language in *Franchise Tax Board* that, although not cited by Humana, could arguably provide a basis for finding jurisdiction here. The court is referring to the following language:

> Congress has given the lower federal courts jurisdiction to hear, originally or by removal from a state court, only those cases in which a well-pleaded complaint establishes either that federal law creates the cause of action *or that the plaintiff's right to relief necessarily depends on resolution of a substantial question of federal law.*

*Franchise Tax Board*, 463 US at 27-28 (emphasis added). Conceivably, one could argue that the resolution of Washington's declaratory judgment action necessarily depends on the resolution of a substantial question of federal law because it involves the interpretation of an ERISA plan. However, since the Court decided *Franchise Tax Board*, it has clarified this language. In *Merrell Dow Pharmaceuticals Inc. v Thompson*, 478 US 804, 814 (1986), the Court concluded that

> the congressional determination that there should be no federal remedy for the violation of this federal statute is tantamount to a congressional conclusion that the presence of a claimed violation of the statute as an element of a state cause of action is insufficiently "substantial" to confer federal-question jurisdiction.

Because there is no indication that Congress has chosen to include in ERISA's civil enforcement provisions a private right of action such as the one Washington has brought here, it appears that there is no "substantial" question of federal law (as defined in *Merrell Dow*) and hence no federal-question jurisdiction. See *Seinfeld v Austen*, 39 F3d 761, 764 (7th Cir 1994), *petition for cert. filed*, 63 USLW 3699 (US Mar 20, 1995) (No. 94-1554).

Because this court lacks subject matter jurisdiction, the case will be remanded to the Circuit Court of Cook County pursuant to 28 USC § 1447(c).

*Appendix E*

ORDERED: The motion to remand is granted. All other pending motions in this case are denied as moot. The case is remanded to the Circuit Court of Cook County.

ENTER:
s/ George W. Lindberg
United States District Judge

DATED: APR 20 1995

## APPENDIX F — STATUTORY PROVISIONS INVOLVED

28 U.S.C. § 1447 – Procedure after removal generally

> (c) A motion to remand the case on the basis of any defect in removal procedure must be made within 30 days after the filing of the notice of removal under section 1446(a). If at any time before final judgment it appears that the district court lacks subject matter jurisdiction, the case shall be remanded. An order remanding the case may require payment of just costs and any actual expenses, including attorney fees, incurred as a result of the removal. A certified copy of the order of remand shall be mailed by the clerk to the clerk of the State court. The State court may thereupon proceed with such case.
>
> (d) An order remanding a case to the State court from which it was removed is not reviewable on appeal or otherwise, except that an order remanding a case to the State court from which it was removed pursuant to section 1443 of this title shall be reviewable by appeal or otherwise.

29 U.S.C. § 1002 – ERISA Definitions

> (21)(A) Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any

discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 1105(c)(1)(B) of this title.

29 U.S.C. § 1132 ERISA Civil enforcement

(a) Persons empowered to bring a civil action
A civil action may be brought –

* * *

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

* * *

*Appendix F*

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 102(f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(b) and (7) of subsection (a) of this section.